FOR MEMORIAL HOSPITAL ASSOCIATION

IN LIEU OF FORM CMS-2552-96(04/2005) PREPARED 11/23/2010 13:19 FORM APPROVED

Ι

Ι

OMB NO. 0938-0050

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

WORKSHEET S PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Ι PROVIDER NO: 14-1305 I Т

I PERIOD

I INTERMEDIARY USE ONLY I FROM 7/ 1/2009 I --AUDITED --DESK REVIEW I TO 6/30/2010 I --INITIAL --REOPENED 1-MCR CODE I --FINAL 00 - # OF REOPENINGS

DATE RECEIVED: INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT

DATE: 11/23/2010

TTMF 13:19

#### PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

# CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:

MEMORIAL HOSPITAL ASSOCIATION

14-1305

FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING

6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND
BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE
WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS
REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

> OFFICER OR ADMINISTRATOR OF PROVIDER(S) TITLE

DATE

# PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX	
	•		A	B	4	
1 HOSPITAL 3 SWING BED - SNF 9 RHC 9 .01 RHC II	1	0 0 0	319,031 90,954 0	781,385 0 583 -14,085		0 0 0
100 TOTAL		0	409,985	767,883		0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503. FOR MEMORIAL HOSPITAL ASSOCIATION

CIATION IN LIEU OF FORM CMS-2552-96 (08/2010)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

I 14-1305 I FROM 7/ 1/2009 I WORKSHEET S-2

I TO 6/30/2010 I HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: SOUTH ADAMS STREET
1.01 CITY: CARTHAGE P.O. BOX: 160 STATE: IL ZIP CODE: 62321-COUNTY: HANCOCK

1.01	CITT. CARTHAGE	SIRIE. IL Z	IF CODE. UZJZI"	COOKITY III	arcock				
HOSPIT	AL AND HOSPITAL-BASED COMPONE	NT IDENTIFICATION;			DATE	1		MENT S	
	COMPONENT	COMPONENT NAME		NPI NUMBER	CERTIF	TED		XVIII 5	
04.00 14.00	HOSPITAL-BASED RHC	MEMORIAL HOSPITAL ASSOCIATION MEMORIAL HOSPITAL BOWEN CLINIC ADAMS STREET CLINIC	2 14-1305 14-2305 14-3456 14-3405	2.01	8/ 8/ 8/ 8/ 2/ 5/ 8/ 1/	/2000 /2000 /1999	N N N	0 0	0 N N
17	COST REPORTING PERIOD (MM/DD	/YYYY) FROM: 7/ 1/2009	то: 6/30/201	LO	1	2			
18	TYPE OF CONTROL				2				
TYPE 0	F HOSPITAL/SUBPROVIDER								
19 20	HOSPITAL SUBPROVIDER				1				
OTHER 21 21.01	IN COLUMN 1. IF YOUR HOSPITA YOUR BED SIZE IN ACCORDANCE COLUMN 2 "Y" FOR YES OR "N"	EITHER (1)URBAN OR (2)RURAL AT THE LIS GEOGRAPHICALLY CLASSIFIED OR WITH CFR 42 412.105 LESS THAN OR EFOR NO. ND IS CURRENTLY RECEIVING PAYMENT	LOCATED IN A RURAL EQUAL TO 100 BEDS,	AREA, IS ENTER IN	)				
	HOSPITAL ADJUSTMENT IN ACCOR FOR NO. IS THIS FACILITY SUB HOSPITALS)? ENTER IN COLUMN	DANCE WITH 42 CFR 412.106? ENTER 1 JECT TO THE PROVISIONS OF 42 CFR 4 2 "Y" FOR YES OR "N" FOR NO.	IN COLUMN 1 "Y" FOF 112.106(c)(2) (PIC	R YES OR "N" KLE AMENDENT					
21.02	OF THE COST REPORTING PERIOD	NEW GEOGRAPHIC RECLASSICATION STATEMENT OF THE PROPERTY OF THE	A? ENTER "Y" FOR Y	YES AND "N"					
21.03	ENTER IN COLUMN 1 YOUR GEOGR IN COLUMN 1 INDICATE IF YOU TO A RURAL LOCATION, ENTER I IN COLUMN 3 THE EFFECTIVE DA	APHIC LOCATION EITHER (1)URBAN OR RECEIVED EITHER A WAGE OR STANDAR! NO COLUMN 2 "Y" FOR YES AND "N" FO! TE (MM/DD/YYYY)(SEE INSTRUCTIONS) NCE WITH 42 CFR 412.105? ENTER IN	(2)RURAL. IF YOU A D GEOGRAPHICAL RECU NO. IF COLUMN 2 DOES YOUR FACILITY	ANSWERED URBAN LASSIFICATION IS YES, ENTER Y CONTAIN	i		Y		
21.04	FOR STANDARD GEOGRAPHIC CLAS	SIFICATION (NOT WAGE), WHAT IS YOU ING PERIOD. ENTER (1)URBAN OR (2)!		-	2		•		
21.05	FOR STANDARD GEOGRAPHIC CLAS	SIFICATION (NOT WAGE), WHAT IS YOU RIOD. ENTER (1)URBAN OR (2)RURAL			2				
21.06	DOES THIS HOSPITAL QUALIFY F	OR THE 3-YEAR TRANSITION OF HOLD POSPECTIVE PAYMENT SYSTEM FOR HOSP:							
21.07	DRA §5105 OR MIPPA §147? (SE DOES THIS HOSPITAL QUALIFY A	E INSTRUC) ENTER "Y" FOR YES, AND S A SCH WITH 100 OR FEWER BEDS UNI TRUCTIONS). IS THIS A SCH OR EACH	"N" FOR NO. DER MIPPA §147? EN	TER "Y" FOR	N				
	OUTPATIENT HOLD HARMLESS PRO FOR NO. (SEE INSTRUCTIONS)	VISION IN ACA SECTION 3121? ENTER	IN COLUMN 2 "Y" FO	OR YES OR "N"	N	N			
21.08	WHICH METHOD IS USED TO DETE IF IT IS BASED ON DATE OF AD	RMINE MEDICAID DAYS ON S-3, PART : MISSION, "2" IF IT IS BASED ON CE' S METHOD DIFFERENT THAN THE METHO	NSUS DAYS, OR "3" I	IF IT IS BASE	, ' <b>'</b>	.,			
22	REPORTING PERIOD? ENTER IN C ARE YOU CLASSIFIED AS A REFE	OLUMN 2, "Y" FOR YES OR "N" FOR N	).		2 N	N			
23	DOES THIS FACILITY OPERATE A	TRANSPLANT CENTER? IF YES, ENTER			N	/ /		-///	
23.02		TIED HEART TRANSPLANT CENTER, ENTER	R THE CERTIFICATION	N DATE IN		/ /		/ /	
23.03	COL. 2 AND TERMINATION DATE IF THIS IS A MEDICARE CERTIF	TIED LIVER TRANSPLANT CENTER, ENTER	R THE CERTIFICATION	N DATE IN		/ /		/ /	
23.04		IED LUNG TRANSPLANT CENTER, ENTER	THE CERTIFICATION	DATE IN		/ /		/ /	
23.05		IN COL. 3. ANTS ARE PERFORMED SEE INSTRUCTION	NS FOR ENTERING CE	RTIFICATION		/ /		/ /	
23.06		TED INTESTINAL TRANSPLANT CENTER,	ENTER THE CERTIFIC	CATION DATE IN	١	/ /		/ /	
23.07		TIED ISLET TRANSPLANT CENTER, ENTE	R THE CERTIFICATION	N DATE IN		/ /		/ /	
24		MENT ORGANIZATION (OPO), ENTER THE	OPO NUMBER IN COL	UMN 2 AND				/ /	
24.01		PLANT CENTER; ENTER THE CCN (PROVI)  FIGURE 12/26/2007)						/ /	

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96 (08/2010) CONTD

| PROVIDER NO: | PERIOD: | PREPARED 11/23/2010
| 14-1305 | FROM 7/ 1/2009 | WORKSHEET S-2
| TO 6/30/2010 | FROM TO 1/2009 | FROM TO 1/2009 | FROM TO 1/2009 | FROM TO 1/2009 | WORKSHEET S-2

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING	
	PAYMENTS FOR 1&R?	N
	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?  IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN	
	EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS	
25.04	DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR	
	NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y"	
26	FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.	
26 01	SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.  ENTER THE APPLICABLE SCH DATES:  BEGINNING: / / ENDING:	, ,
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING:	/ /
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y 8/8/2000
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR	
28.01	THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1.	1 2 3 4
	ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	0 0.0000 0.0000
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL	
	INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR	0.00 0
	TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE	
	OR TWO CHARACTER CODE IF RURAL BASED FACILITY	
	A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE	
	USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL	
	EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES	
28 03	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) STAFFING	% Y/N 0.00%
28.04	RECRUITMENT	0.00%
28.05 28.06	RETENTION TRAINING	0.00% 0.00%
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE	N
30	AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?  DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS	Y
30.01	HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH?	
	SEE 42 CFR 413.70	N
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	Υ
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST	
	BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD	
	NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42	
31.01	CFR 412.113(c). IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42	Y
	CFR 412.113(c). IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42	N
	CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42	
31.05	CFR 412.113(c). IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42	N
	CFR 412.113(c).	N
	LANEOUS COST REPORT INFORMATION	N
32 33	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO	N
	IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR	
	NO IN COLUMN 2	N .
34 35	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?  HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N N
35.01 35.02		N
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX WORKSHEET S-2 14-1305 IDENTIFICATION DATA I TO 6/30/2010 I XVIII XIX PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL 1 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE Ν N 36.01 WITH 42 CFR 412.320? (SEE INSTRUCTIONS) DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? TITLE XIX INPATIENT SERVICES DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? Ν 38.03 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? 38.04 40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). 40.01 NAME: FI/CONTRACTOR # FI/CONTRACTOR NAME 40.02 STREET: P.O. BOX: 40.03 CITY: STATE: ZIP CODE: 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?
42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?
44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?
45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT?
46 CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
47 ON THERE A CHANGE IN THE STATISTICAL BASIS?
48 ON THERE A CHANGE IN THE ORDER OF ALLOCATION?
48 ON THERE A CHANGE IN THE ORDER OF ALLOCATION? N 10/15/2009 N 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? N IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS). IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.) OUTPATIENT OUTPATIENT OUTPATIENT PART B RADIOLOGY DIAGNOSTIC PART A ASC 1 3 -4 47.00 HOSPITAL Ν N Ν Ν DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. ENDING: 53.01 MDH PERIOD: BEGINNING: LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 271,514 PAID LOSSES: AND/OR SELF INSURANCE: ٥ 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N

55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.		N		
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN	DATE 0	Y OR N	LIMIT Y OR N 2 3	FEES 4
	<ol> <li>IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE,</li> </ol>		N	0.00	0
56.01	THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY, ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR			0.00	0
	SUBSEQUENT PERIOD AS APPLICABLE. THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00 0.00	0

#### MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

#### SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS
ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH"
DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY).

		COMPLEX STATISTICAL	DATA		1		1 10 6/30/	2010 1	PARI I
		COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P TITLE V	TITLE XVIII	NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1		ADULTS & PEDIATRICS	1 18	2 8 6,885	2.01 49,680.00	3	4 1,255	4.01	5 355
2 2 3 4	01	HMO - (IRF PPS SUBPROVIDER) ADULTS & PED-SB SNF ADULTS & PED-SB NF		,	,,,,,,,,,,,	•	117 597		
5 6 11		TOTAL ADULTS AND PEDS INTENSIVE CARE UNIT NURSERY	18	6,885 4 180	49,680.00 48.00		1,852 2		355 97
12		TOTAL	22	7,065	49,728.00		1,854		452
17 24 24	01	RPCH VISITS OTHER LONG TERM CARE RHC -BOWEN	5	7 20,805			595 351		
25 26 27 28 28 29		RHC-WOMEN & FAMILY CLINIC TOTAL OBSERVATION BED DAYS AMBULANCE TRIPS EMPLOYEE DISCOUNT DAYS EMP DISCOUNT DAYS -IRF LABOR & DELIVERY DAYS	79	9			331		
		COMPONENT	ADMITTED		O/P VISITS TOTAL ALL PATS	TOTAL OBSE	RVATION BEDS NOT ADMITTED	TOTAL	& RES. FTES LESS I&R REPL NON-PHYS ANES 8
1		ADULTS & PEDIATRICS	5.01	5.02	6 2,070	6.01	6.02	7	•
2 2 3 4 5	01	HMO . HMO - (IRF PPS SUBPROVIDER) ADULTS & PED-SB SNF ADULTS & PED-SB NF TOTAL ADULTS AND PEDS			639 33 2,742				
6 11 12 13		INTENSIVE CARE UNIT NURSERY TOTAL RPCH VISITS			2 246 2,990				
17 24 24	01	OTHER LONG TERM CARE RHC -BOWEN RHC-WOMEN & FAMILY CLINIC			15,781 3,215 5,956				
25 26 27 28		TOTAL OBSERVATION BED DAYS AMBULANCE TRIPS EMPLOYEE DISCOUNT DAYS			557	112	445		
28 29	01	EMP DISCOUNT DAYS -IRF LABOR & DELIVERY DAYS			-				
			I & R FTES	FULL TIMEMPLOYEES	ME EQUIV NONPAID	TITLE	DISCHARGES	TITLE	TOTAL ALL
		COMPONENT	NET 9	ON PAYROLL 10	WORKERS 11	V 12	XVIII 13	XIX 14	PATIENTS 15
1 2		ADULTS & PEDIATRICS	9	10	11	14	317	123	
2	01	HMO - (IRF PPS SUBPROVIDER) ADULTS & PED-SB SNF							
4 5 6		ADULTS & PED-SB NF TOTAL ADULTS AND PEDS INTENSIVE CARE UNIT	٠						
11 12 13		NURSERY TOTAL RPCH VISITS		156.87			317	123	3 594
17 24		OTHER LONG TERM CARE RHC -BOWEN		47.20 4.00					
24 25 26	01	RHC-WOMEN & FAMILY CLINIC TOTAL OBSERVATION BED DAYS		6.30 214.37					
27 28 28	01	AMBULANCE TRIPS EMPLOYEE DISCOUNT DAYS EMP DISCOUNT DAYS -IRF							
29		LABOR & DELIVERY DAYS							

IN LIEU OF FORM CMS-2552-96 S-8 (09/2000) Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION I PERIOD: I PREPARED 11/23/2010 I FROM 7/ 1/2009 I WORKSHEET S-8 PROVIDER NO: PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED 14-1305 COMPONENT NO: 6/30/2010 I I TO HEALTH CENTER PROVIDER STATISTICAL DATA 14-3456 RHC 1 CLINIC ADDRESS AND IDENTIFICATION STREET: 209 EAST 5TH ST CITY: BOWEN STATE: IL ZIP COL DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN 1.01 CITY: IL ZIP CODE: 62316 COUNTY: HANCOCK GRANT AWARD DATE SOURCE OF FEDERAL FUNDS: 3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT) MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT) APPALACHIAN REGIONAL COMMISSION LOOK-ALIKES OTHER (SPECIFY) **BILLING PHYSICIAN** PHYSICIAN INFORMATION: NUMBER NAME PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT HOURS OF **PHYSICIAN** SUPERVISION NAME 10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) 11 FACILITY HOURS OF OPERATIONS (1) WEDNESDAY THURSDAY FRIDAY SATURDAY FROM TO FROM T MONDAY TUESDAY TYPE OPERATION 0 800 1700 800 1800 800 1700 800 1700 800 1600 CLINIC 12 (1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION) LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK, FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400 13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? Ν IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN 14 COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. PROVIDER NAME: PROVIDER NUMBER: 15 TITLE XVIII TITLE XIX TITLE V HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS  $^2$ , 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & 16 RESIDENTS. 17 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.

IN LIEU OF FORM CMS-2552-96 S-8 (09/2000) Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION I PERIOD: I PREPARED 11/23/2010 I FROM 7/ 1/2009 I WORKSHEET S-8 PROVIDER NO: PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED 14-1305 HEALTH CENTER PROVIDER STATISTICAL DATA COMPONENT NO: 6/30/2010 I 14-3405 RHC 2 CLINIC ADDRESS AND IDENTIFICATION STREET: 213 SOUTH ADAMS STREET 1.01 CITY: HANCOCK CARTHAGE STATE: IL ZIP CODE: 62321 COUNTY: DESIGNATION (FOR FOHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN DATE SOURCE OF FEDERAL FUNDS: GRANT AWARD COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT) MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT) APPALACHIAN REGIONAL COMMISSION LOOK-ALIKES 8 OTHER (SPECIFY) PHYSICIAN INFORMATION: **PHYSICIAN** BILLING NUMBER NAME 9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT **PHYSICIAN** HOURS OF NAME SUPERVISION 10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FOHC? IF YES, INDICATE NUMBER OF OTHER 11 OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) FACTLITY HOURS OF OPERATIONS (1) SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURFROM TO FROM TO THURSDAY THURSDAY FRIDAY SATURFROM TO FROM TO FROM TO FROM TO THE FROM T SATURDAY TYPE OPERATION 2 800 2000 800 2000 800 1700 800 1700 800 1700 12 CLINIC (1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION) LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400 13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN 14 COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. 15 PROVIDER NAME: TITLE XIX TITLE XVIII TITLE V HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & 16 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS. 17

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101

4000

4100 4300

4400

4401

4600

4900 5000 5300

5600

6000

6100

6200

4950

6500

8800

9600

9800

100.01 7951

63.01 4951

63.50 6310

63.51 6311

FOR MEMORIAL HOSPITAL ASSOCIATION

114.598

395,235 69,291 744,829 213,537

60,744 53,518 52,404 11,417 399,811

519,115

363.790

599,090

2,936

1.116,178 1,116,178

72,473 327,731

12,875,759

12,974,584

78,336

19,152

1,337

7,804

399,512

348,779

821,212 69,291 1,191,697 268,177 60,744 217,492 52,404 11,417 429,310

666,274

2,065,119

1,090,151

39,072

234,913

22,152,155

22,400,757

220,692

19,152

8,758

-236,068

1,193

-1,193

-234,390

-29,436

-68.193

6,396

61,797

-0-

-1,116,178

399,512

112,711

821.212

268,177 60,744

218,685

10,224

429,310

666,274

1,830,729

1,092,382

39,072

219,145

834,442

22,083,962

22,400,757

282,489 25,548 8,758

1,191,697

69,291

IN LIEU OF FORM CMS-2552-96(9/1996) I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010 I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A

# DECLASSICICATION AND ADDISTMENT OF

ANCILLARY SRVC COST CNTRS
3700 OPERATING ROOM

3900 DELIVERY ROOM & LABOR ROOM

RESPIRATORY THERAPY PHYSICAL THERAPY

ELECTROCARDIOLOGY

RADIOLOGY-DIAGNOSTIC

DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS

RHC-WOMEN & FAMILY CLINIC

OTHER REIMBURS COST CNTRS

OTHER CAPITAL RELATED COSTS

NONREIMBURS COST CENTERS

AMBULANCE SERVICES SPEC PURPOSE COST CENTERS
INTEREST EXPENSE

NAUVOO APARTMENTS

WHOLE BLOOD & PACKED RED BLOOD CELLS

MEDICAL SUPPLIES CHARGED TO PATIENTS

OBSERVATION BEDS (NON-DISTINCT PART)
OTHER OUTPATIENT SERVICE COST CENTER
DIABETIC EDUCATION
RHC -BOWEN

GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES

ANESTHESIOLOGY

RADIOISOTOPE

LABORATORY

GEO PSYCH

CLINIC

**EMERGENCY** 

SUBTOTALS

**BEAUTY SHOP** 

TOTAL

RI		IFICATION AND ADJUSTMENT OF IAL BALANCE OF EXPENSES	I 1	14-1305	I FROM 7/ 1/2009 I TO 6/30/2010		TA
	COST		SALARIES	OTHER	TOTAL	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE
	CLIVIE	N.	1	2	3	4	5
		GENERAL SERVICE COST CNTR	-	-	3	,	-
	0300	NEW CAP REL COSTS-BLDG & FIXT		1,052,786	1,052,786	-1,016,278	36,508
<b>01</b>	0301			139,828	139,828	-30,981	108,847
	0302			133,020	155,020	2,023,246	2,023,246
	0400	NEW CAP REL COSTS-MVBLE EQUIP		683,174	683,174	35,379	718,553
-01	0401	NEW CAP REL COSTS-NH ME		003,11.	****	24,585	24,585
	0500	EMPLOYEE BENEFITS		2,334,276	2,334,276	-57,296	2,276,980
.01	0501	SHARED HUMAN RESOURCES	57,768	27,692	85,460		85,460
	0660	HOSPITAL ONLY BUS OFF AND A&G	265,209	1,129,457	1,394,666	315,874	1,710,540
	0661		828,279	262,509	1,090,788	231	1,091,019
	0800	OPERATION OF PLANT	134,175	570,785	704,960		704,960
.01	0801	OPERATION OF PLANT NURSING HOME	83,632	256,531	340,163		340,163
)	0900	LAUNDRY & LINEN SERVICE	1,466	49,035	50,501		50,501
)	1000	HOUSEKEEPING	96,725	51,126	147,851		147,851
.01	1001	HOUSEKEEPING NURSING HOME	87,892	7,506	95,398		95,398
	1100	DIETARY	206,145	150,861	357,006	-173,802	183,204
<u>}</u>	1200	CAFETERIA	•	·		173,802	173,802
1	1400	NURSING ADMINISTRATION	101,937	10,990	112,927		112,927
i	1500	CENTRAL SERVICES & SUPPLY	•				
,	1600	PHARMACY					
,	1700	MEDICAL RECORDS & LIBRARY	167,457	20,036	187,493	39,360	226,853
}	1800	SOCIAL SERVICE	16,165		16,165		16,165
)	2000	NONPHYSICIAN ANESTHETISTS	297,025	16,307	313,332		313,332
		INPAT ROUTINE SRVC CNTRS					
i	2500	ADULTS & PEDIATRICS	1,062,223	15,067	1,077,290	114,806	1,192,096
i	2600	INTENSIVE CARE UNIT					404 000
}	3300	NURSERY				121,889	121,889
,	3600	OTHER LONG TERM CARE	1,049,179	973,292	2,022,471	-9,399	2,013,072
		ANGTI LABOU COMO COCO CONTRO					

284.914

340,975

425,977

446,868

54,640

163,974

29,499

147,159

491,061

36,136

162,440 536,147

9,276,396

142,356

9,426,173

1,701,329

MCRIF32

FOR MEMORIAL HOSPITAL ASSOCIATION

# RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

	ST COST CENTER DESCRIPTION	ADJUSTMENTS	
CEN	TER	6	FOR ALLOC 7
	GENERAL SERVICE COST CNTR	O	,
3 030	O NEW CAP REL COSTS-BLDG & FIXT		36,508
3.01 030			108,847
3.02 030 4 040		-20,407	2,002,839
4.01 040			718,553 24,585
5 050		-81,595	2,195,385
5.01 050	1 CHARED HIMAN DECOURCES		85,460
6.01 066	0 HOSPITAL ONLY BUS OFF AND A&G	-458,661	1,251,879
6.02 066	I OTHER ADMINISTRATIVE AND GENERAL SHA	-1,033	1,089,986
8 080 8.01 080	O OPERATION OF PLANT 1 OPERATION OF PLANT NURSING HOME	-75,593	629,367 340,163
9 090			50,501
10 100	0 HOUSEKEEPING		147,851
10.01 100			95,398
11 110		-81,330	101,874
12 120 14 140		-42,666	131,136 112,927
	O CENTRAL SERVICES & SUPPLY		112,327
	0 PHARMACY		
17 170	0 MEDICAL RECORDS & LIBRARY	-4,656	222,197
18 180			16,165
20 200	0 NONPHYSICIAN ANESTHETISTS INPAT ROUTINE SRVC CNTRS		313,332
25 250	0 ADULTS & PEDIATRICS		1,192,096
26 260	O INTENSIVE CARE UNIT		_,,_,
	0 NURSERY	-90	121,799
36 360	O OTHER LONG TERM CARE	-90 -112,912	1,900,160
37 370	ANCILLARY SRVC COST CNTRS  0 OPERATING ROOM		399,512
	0 DELIVERY ROOM & LABOR ROOM		112,711
40 400			,,
41 410	0 RADIOLOGY-DIAGNOSTIC		821,212
	0 RADIOISOTOPE		69,291
	0 LABORATORY	-4,069	1,187,628 267,826
	1 GEO PSYCH 0 WHOLE BLOOD & PACKED RED BLOOD CELLS	-351	60,744
	0 RESPIRATORY THERAPY		218.685
50 500	O PHYSICAL THERAPY		52,404
	0 ELECTROCARDIOLOGY		10,224
55 550		-7,134	422,176
56 560	O DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS		666,274
60 600		-1,174,934	655,795
	0 EMERGENCY	-111,682	980,700
62 620	O OBSERVATION BEDS (NON-DISTINCT PART)		
	0 OTHER OUTPATIENT SERVICE COST CENTER 1 DIABETIC EDUCATION		39,072
	O RHC -BOWEN	-3,076	216,069
63.51 631		-10,374	824,068
	OTHER REIMBURS COST CNTRS	,	•
65 650	O AMBULANCE SERVICES		
00 000	SPEC PURPOSE COST CENTERS		^
88 880 90 900	0 INTEREST EXPENSE 0 OTHER CAPITAL RELATED COSTS		-0- -0-
95	SUBTOTALS	-2,190,563	
	NONREIMBURS COST CENTERS	-,,	,
96 960	O GIFT, FLOWER, COFFEE SHOP & CANTEEN		202 (22
	O PHYSICIANS' PRIVATE OFFICES		282,489
	0 NAUVOO APARTMENTS 1 BEAUTY SHOP		25,548 8,758
100.01 /93	TOTAL	-2,190,563	
		-,,	,,

FOR MEMORIAL HOSPITAL ASSOCIATION | IN LIEU OF FORM CMS-2552-96(7/2009) | I PROVIDER NO: | I PERIOD: | I PREPARED 11/23/2010 | I 14-1305 | I FROM 7/ 1/2009 | I NOT A CMS WORKSHEET | I TO 6/30/2010 | I COST CENTERS USED IN COST REPORT

LINE NO	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	GENERAL SERVICE COST NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-HDG & FIXT NEW CAP REL COSTS-HDG & FIXT (NEW B NEW CAP REL COSTS-WYBLE EQUIP NEW CAP REL COSTS-HM ME EMPLOYEE BENEFITS SHARED HUMAN RESOURCES HOSPITAL ONLY BUS OFF AND A&G OTHER ADMINISTRATIVE AND GENERAL SHA OPERATION OF PLANT OPERATION OF PLANT OPERATION OF PLANT NURSING HOME LAUNDRY & LINEN SERVICE HOUSEKEEPING HOUSEKEEPING NURSING HOME	0300	
3.01	NEW CAP REL COSTS-NH BLDG	0301	NEW CAP REL COSTS-BLDG & FIXT
3.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0302	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4.01	NEW CAP REL COSTS-NH ME	0401	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
5.01	SHARED HUMAN RESOURCES	0501	EMPLOYEE BENEFITS
6.01	HOSPITAL ONLY BUS OFF AND A&G	0660	OTHER ADMINISTRATIVE AND GENERAL
6.02	OTHER ADMINISTRATIVE AND GENERAL SHA	0661	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
8.01	OPERATION OF PLANT NURSING HOME	0801	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
			HOUSEKEEPING
11	DIETARY	1100	
12	CAFETERIA	1200	
14 15	NURSING ADMINISTRATION	1400	
16	CENTRAL SERVICES & SUPPLY	1500	
17	CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY	1600	
18	SOCIAL SERVICE	1700 1800	
20		2000	
	NONPHYSICIAN ANESTHETISTS INPAT ROUTINE SRVC C	2000	
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST	3000	
37	ODERATTIC BOOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESTOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC RADIOISOTOPE LABORATORY	4100	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
44.02	GEO PSYCH	4401	LABORATORY
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600 4900	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	PHYSICAL THERAPY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST	***	
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	AND DISTRICT CERVICE COST COUTER
63	DIABETIC EDUCATION	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.01	DIABETIC EDUCATION	4951 6310	DIREK UUTPATIENT SERVICE COST CENTER
63.30	RHC -BOWEN	6310	RURAL HEALTH CLINIC #####
63.31	RHC-WOMEN & FAMILY CLINIC	9211	RURAL HEALIN CEINIC #####
65	CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER DIABETIC EDUCATION RHC -BOWEN RHC-WOMEN & FAMILY CLINIC OTHER REIMBURS COST AMBULANCE SERVICES	6500	
03	SPEC PURPOSE COST CE	6300	•
88		8800	
		9000	
95	INTEREST EXPENSE OTHER CAPITAL RELATED COSTS SUBTOTALS	0000	
	NONREIMBURS COST CEN	0000	
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
QR	DHYSTCTANS' DDTVATE GEETCES	9800	
100	NAUVOO APARTMENTS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	BEAUTY SHOP	7951	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

Health Financial Systems MCRIF32

RECLASSIFICATIONS

FOR MEMORIAL HOSPITAL ASSOCIATION

IN LIEU OF FORM CMS-2552-96 (09/1996) PROVIDER NO: | PERIOD: | PREPARED 11/23/2010 141305 | FROM 7/ 1/2009 | WORKSHEET A-6 | TO 6/30/2010 |

----- INCREASE -----LINE **EXPLANATION OF RECLASSIFICATION** (1) COST CENTER SALARY OTHER NO NEW CAP REL COSTS-NH ME NEW CAP REL COSTS-BLDG & FIXT (NEW B NAUVOO APARTMENTS 24,585 1,013,708 1 TO RECLASS DEPRECIATION EXPENSE 3.02 6,396 73,444 4 TO RECLASS CAFETERIA 5 TO RECLASS RHC DEPR EXPENSE 100,358 CAFETERIA 12 2,570 RHC -BOWEN OTHER ADMINISTRATIVE AND GENERAL SHA 231 6 TO RECLASS NURSING EXPENSE 6.02 35,379 NEW CAP REL COSTS-MVBLE EQUIP HOSPITAL ONLY BUS OFF AND A&G NEW CAP REL COSTS-BLDG & FIXT (NEW B 7 TO RECLASS INTEREST 6.01 71,261 1,009,538 3.02 2,555 2,727 10 TO RECLASS DELIVERY AND LABOR ADULTS & PEDIATRICS NURSERY 33 119,162 39,360 12 TO RECLASS BILLING & TRANSCRIP EXP MEDICAL RECORDS & LIBRARY 17 6.01 244,613 HOSPITAL ONLY BUS OFF AND A&G 13 14 7,708 H ELECTROCARDIOLOGY 17 TO RECLASS EKG TIME 53 RESPIRATORY THERAPY RHC-WOMEN & FAMILY CLINIC PHYSICIANS' PRIVATE OFFICES 49 8,901 19 TO RECLASS DR LYNCH AND JONES TIME 63.51 72,625 4,632 83,048 21 RECLASS S WATSON TO SWING 22 RECLASS ALLOWABLE PHYSICIAN FICA 23 25 60 ADULTS & PEDIATRICS 627 55.065 CLINIC 61 2,231 **EMERGENCY** 24 TO RECLASS CLINIC CAFETERIA COSTS 8,541 CLINIC 797,292 2,303,597 36 TOTAL RECLASSIFICATIONS

<sup>(1)</sup> A letter (A, B, etc) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

Health Financial Systems MCRIF32

RECLASSIFICATIONS

FOR MEMORIAL HOSPITAL ASSOCIATION

			DECREASE			
	CODE		LINE			A-7
EXPLANATION OF RECLASSIFICATION	(1)	COST CENTER	NO	SALARY	OTHER	REF
	1	6	7	8	9	10
1 TO RECLASS DEPRECIATION EXPENSE	Α	NEW CAP REL COSTS-NH BLDG	3.01		24,585	9 9
2		NEW CAP REL COSTS-BLDG & FIXT	3		1,013,708	9
3		NEW CAP REL COSTS-NH BLDG	3.01		6,396	9
4 TO RECLASS CAFETERIA	8	DIETARY	11	100,358	73,444	
5 TO RECLASS RHC DEPR EXPENSE	c	NEW CAP REL COSTS-BLDG & FIXT	3		2,570	9
6 TO RECLASS NURSING EXPENSE	D	OTHER LONG TERM CARE	36	231		
7 TO RECLASS INTEREST	E	INTEREST EXPENSE	88		1,116,178	11
9						11
10 TO RECLASS DELIVERY AND LABOR	F	DELIVERY ROOM & LABOR ROOM	39	111,624	2,555	
11	•	DELIVERY ROOM & LABOR ROOM	39	119,162	2,727	
12 TO RECLASS BILLING & TRANSCRIP EXP	G	CLINIC	60	,	39,360	
13	_	CLINIC	60	181,379	•	
14		RHC -BOWEN	63.50	18,338		
15		RHC-WOMEN & FAMILY CLINIC	63.51	23,645		
16		PHYSICIANS' PRIVATE OFFICES	98	21,251		
17 TO RECLASS EKG TIME	н	RESPIRATORY THERAPY	49	7,708		
18		ELECTROCARDIOLOGY	53	·	8,901	
19 TO RECLASS DR LYNCH AND JONES TIME	I	CLINIC	60	72,625	4,632	
20		RHC-WOMEN & FAMILY CLINIC	63.51	83,048		
21 RECLASS S WATSON TO SWING	J	OTHER LONG TERM CARE	36	627		
22 RECLASS ALLOWABLE PHYSICIAN FICA		EMPLOYEE BENEFITS	5	57,296		
23 24 TO RECLASS CLINIC CAFETERIA COSTS		OTHER LONG TERM CARE	36		8,541	
36 TOTAL RECLASSIFICATIONS	_	OTHER CORD TERM CARE	30	797,292	2,303,597	

<sup>(1)</sup> A letter (A, B, etc) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A EXPLANATION : TO RECLASS DEPRECIATION	EXPENSE				
LINE COST CENTER  1.00 NEW CAP REL COSTS-NH ME  2.00 NEW CAP REL COSTS-BLDG & FIXT  3.00 NAUVOO APARTMENTS  TOTAL RECLASSIFICATIONS FOR CODE A	LINE 4.01 3.02	AMOUNT 24,585 1,013,708 6,396 1,044,689	COST CENTER  NEW CAP REL COSTS-NH BLDG  NEW CAP REL COSTS-BLDG & FIXT  NEW CAP REL COSTS-NH BLDG	SE LINE 3.01 3 3.01	AMOUNT 24,585 1,013,708 6,396 1,044,689
RECLASS CODE: B EXPLANATION : TO RECLASS CAFETERIA					
INCREAS	E		DECREAS	SE	
LINE COST CENTER  1.00 CAFETERIA  TOTAL RECLASSIFICATIONS FOR CODE B	LINE 12	AMOUNT 173,802 173,802	COST CENTER DIETARY	11	AMOUNT 173,802 173,802
RECLASS CODE: C EXPLANATION: TO RECLASS RHC DEPR EXPE					
I THE COST CENTER	E		COST CONTER	SE	
LINE COST CENTER  1.00 RHC -BOWEN TOTAL RECLASSIFICATIONS FOR CODE C	63.50	2,570 2,570	COST CENTER NEW CAP REL COSTS-BLDG & FIXT	3	2,570 2,570
RECLASS CODE: D EXPLANATION : TO RECLASS NURSING EXPEN					
INF COST CENTER	E	AMOUNT	COST CENTER	SE	
LINE COST CENTER  1.00 OTHER ADMINISTRATIVE AND GENER TOTAL RECLASSIFICATIONS FOR CODE D	6.02	231 231	OTHER LONG TERM CARE	36	231 231
RECLASS CODE: E EXPLANATION : TO RECLASS INTEREST					
LINE COST CENTER	E	AMOUNT	DECREAS COST CENTER INTEREST EXPENSE	SE	AMOUNT
1.00 NEW CAP REL COSTS-MVBLE EQUIP	4	35,379	INTEREST EXPENSE	88	1,116,178
LINE COST CENTER  1.00 NEW CAP REL COSTS-MVBLE EQUIP  2.00 HOSPITAL ONLY BUS OFF AND A&G  3.00 NEW CAP REL COSTS-BLDG & FIXT  TOTAL RECLASSIFICATIONS FOR CODE E	3.02	1,009,538 1,116,178			0 1,116,178
RECLASS CODE: F EXPLANATION : TO RECLASS DELIVERY AND	LABOR				
LINE COST CENTER	SE	AMOUNT	COST CENTER	SE	AMOUNT
LINE COST CENTER 1.00 ADULTS & PEDIATRICS 2.00 NURSERY	25 25	114,179	DELIVERY ROOM & LABOR ROOM	39	114,179
2.00 NURSERY TOTAL RECLASSIFICATIONS FOR CODE F	33	121,889 236,068	COST CENTER DELIVERY ROOM & LABOR ROOM DELIVERY ROOM & LABOR ROOM	39	121,889 236,068
RECLASS CODE: G EXPLANATION : TO RECLASS BILLING & TRA	ANSCRIP EXP				
LINE COST CENTER	E LINE	AMOUNT	COST CENTER	SE LINE	AMOUNT
1.00 MEDICAL RECORDS & LIBRARY	17	39,360	CLINIC	60	39,360
2.00 HOSPITAL ONLY BUS OFF AND A&G 3.00	6.01	244,613 0	CLINIC RHC -BOWEN	60 63.50	181,379 18,338
4.00 5.00		0 0	RHC-WOMEN & FAMILY CLINIC PHYSICIANS' PRIVATE OFFICES	63.51 98	23,645 21,251
TOTAL RECLASSIFICATIONS FOR CODE G		283,973	PHISICIANS PRIVATE OFFICES	<b>30</b>	283,973
RECLASS CODE: H EXPLANATION : TO RECLASS EKG TIME					
INCREASE			DECREAS		
LINE COST CENTER 1.00 ELECTROCARDIOLOGY	LINE 53	AMOUNT 7,708	COST CENTER RESPIRATORY THERAPY	LINE 49	AMOUNT 7,708
2.00 RESPIRATORY THERAPY TOTAL RECLASSIFICATIONS FOR CODE H	49	8,901 16,609	ELECTROCARDIOLOGY	53	8,901 16,609

 Health Financial Systems
 MCRIF32
 FOR MEMORIAL HOSPITAL ASSOCIATION
 IN LIEU OF FORM CMS-2552-96 (09/1996)

 RECLASSIFICATIONS
 | PROVIDER NO: | PERIOD: | PREPARED 11/23/2010

 RECLASSIFICATIONS
 | 141305 | FROM 7/ 1/2009 | WORKSHEET A-6

 | TO
 6/30/2010 | NOT A CMS WORKSHEET

RECLASS CODE: I EXPLANATION: TO RECLASS DR LYNCH AND	O JONES TIME				
INCRE	NCE		DECR	ASE	
LINE COST CENTER 1.00 RHC-WOMEN & FAMILY CLINIC 2.00 PHYSICIANS' PRIVATE OFFICES TOTAL RECLASSIFICATIONS FOR CODE I	LINE 63.51 98	AMOUNT 77,257 83,048 160,305	COST CENTER CLINIC RHC-WOMEN & FAMILY CLINIC	LINE	AMOUNT
RECLASS CODE: J EXPLANATION : RECLASS S WATSON TO SW	ING				
INCRE	ASF		DECRI	ASE	
LINE COST CENTER	LINE	TALIOMA			
1.00 ADULTS & PEDIATRICS	25	627	OTHER LONG TERM CARE	36	627
1.00 ADULTS & PEDIATRICS TOTAL RECLASSIFICATIONS FOR CODE J		627			627
RECLASS CODE: K EXPLANATION : RECLASS ALLOWABLE PHYS	ICIAN FICA				
INCRE	ASE		DECRI		
LINE COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00 CLINIC	60	55,065	EMPLOYEE BENEFITS	5	57,296
LINE COST CENTER 1.00 CLINIC 2.00 EMERGENCY TOTAL RECLASSIFICATIONS FOR CODE K	61	2,231			0
TOTAL RECLASSIFICATIONS FOR CODE K		57,296			57,296
RECLASS CODE: L EXPLANATION : TO RECLASS CLINIC CAFE	TERIA COSTS				
INCRE	ASE		DECRI		
LINE COST CENTER 1.00 CLINIC	LINE	AMOUNT	COST CENTER OTHER LONG TERM CARE	LINE	AMOUNT
1.00 CLINIC	60	8,541	OTHER LONG TERM CARE	36	8,541
1.00 CLINIC TOTAL RECLASSIFICATIONS FOR CODE L		8,541			8,541

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-7

COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS I I TO 6/30/2010 I PARTS I & II

# PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	DESTABLING		ACQUISITIONS		DISPOSALS	ENDING	FULLY DEPRECIATED
		BEGINNING BALANCES 1	PURCHASES 2	PURCHASES DONATION 2 3		AND RETIREMENTS 5	BALANCE 6	ASSETS 7
1	LAND	_	_	_				
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

### PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING		ACQUISITIONS		DISPOSALS AND	ENDING	FULLY DEPRECIATED
		BALANCES 1	PURCHASES 2	DONATION 3	TOTAL 4	RETIREMENTS 5	BALANCE 6	ASSETS 7
1	LAND	521,757					521,757	
2	LAND IMPROVEMENTS	276.320	199.304		199,304	133,744	341,880	
3	BUILDINGS & FIXTURE	5.715.249	21.104.942		21.104.942	3,279,127	23,541,064	
4	BUILDING IMPROVEMEN	-,,	,,			•		
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	6,809,500	1.349.273		1,349,273	1,544,466	6,614,307	
7	SUBTOTAL	13,322,826	22,653,519		22,653,519	4,957,337	31,019,008	
8	RECONCILING ITEMS				•	•		
9	TOTAL	13,322,826	22,653,519		22,653,519	4,957,337	31,019,008	

* NEW CAP REL COSTS-BL 3 01 NEW CAP REL COSTS-NH 3 02 NEW CAP REL COSTS-BL 4 NEW CAP REL COSTS-BL	GROSS ASSETS 1 341,880 3,788,440 20,274,381 6,083,212	CENTERS COMPUTATION CAPITLIZED ( LEASES 2	FOR RATIO 3 341,880 3,788,440 20,274,381 6,083,212	RATIO 4 .011022 .122133 .653611 .196112	ALLC INSURANCE 5		ER CAPITAL OTHER CAPITAL RELATED COSTS 7	TOTAL 8
4 01 NEW CAP REL COSTS-NH	531,095		531,095	.017122				
5 TOTAL	31,019,008		31,019,008	1.000000				
DESCRIPTION			SUMMARY OF O	LD AND NEW CAP	ITAL	OTHER CAPITAL		
* 3 NEW CAP REL COSTS-BL	DEPRECIATION 9 36,508	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	RELATED COST	TOTAL (1) 15 36,508	
3 01 NEW CAP REL COSTS-NH 3 02 NEW CAP REL COSTS-BL	108,847 1,012,945		989,894				108,847 2,002,839	
4 NEW CAP REL COSTS-MV 4 01 NEW CAP REL COSTS-NH	683,174 24,585		35,379				718,553 24,585	
5 TOTAL	1,866,059		1,025,273				2,891,332	
PART IV - RECONCILIATION OF A	AMOUNTS FROM W	ORKSHEET A,		S 1 THRU 4 LD AND NEW CAP	PITAL	OTHER CAPITAL		
*	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES 13	RELATED COST	TOTAL (1) 15	
3 NEW CAP REL COSTS-BL 3 01 NEW CAP REL COSTS-NH	9 1,052,786 139,828	10	11	12	13	14	1,052,786 139,828	
3 02 NEW CAP REL COSTS-BL 4 NEW CAP REL COSTS-MV	683,174						683,174	
4 01 NEW CAP REL COSTS-NH 5 TOTAL	1,875,788						1,875,788	

 <sup>\*</sup> All lines numbers except line 5 are to be consistent with workheet A line numbers for capital cost centers.
 (1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.
 Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED DESCRIPTION (1) WKST. (2) BASIS/CODE COST CENTER AMOUNT LINE NO 4 \*\*COST CENTER DELETED\*\*
\*\*COST CENTER DELETED\*\* INVST INCOME-OLD BLDGS AND FIXTURES
INVESTMENT INCOME-OLD MOVABLE EQUIP 1 INVST INCOME-NEW BLDGS AND FIXTURES NEW CAP REL COSTS-BLDG & INVESTMENT INCOME-NEW MOVABLE EQUIP INVESTMENT INCOME-OTHER TRADE, QUANTITY AND TIME DISCOUNTS REFUNDS AND REBATES OF EXPENSES NEW CAP REL COSTS-MVBLE E 3.02 9 -763 NEW CAP REL COSTS-BLDG & RENTAL OF PRVIDER SPACE BY SUPPLIERS TELEPHONE SERVICES HOSPITAL ONLY BUS OFF AND 6.01 -2,875 10 11 12 TELEVISION AND RADIO SERVICE PARKING LOT PROVIDER BASED PHYSICIAN ADJUSTMENT -1,230,963 A-8-2 SALE OF SCRAP, WASTE, ETC.
RELATED ORGANIZATION TRANSACTIONS 13 14 15 16 17 A-8-1 -75,593 LAUNDRY AND LINEN SERVICE CAFETERIA--EMPLOYEES AND GUESTS RENTAL OF QTRS TO EMPLYEE AND OTHRS 12 CAFETERIA -42,666 В SALE OF MED AND SURG SUPPLIES
SALE OF DRUGS TO OTHER THAN PATIENTS
SALE OF MEDICAL RECORDS & ABSTRACTS
NURSG SCHOOL (TUITN, FEES, BOOKS, ETC.) 18 19 20 21 22 23 24 25 17 MEDICAL RECORDS & LIBRARY В -4,656 VENDING MACHINES -1,472 DIETARY INCOME FROM IMPOSITION OF INTEREST INTRST EXP ON MEDICARE OVERPAYMENTS ADJUSTMENT FOR RESPIRATORY THERAPY RESPIRATORY THERAPY A-8-3/A-8-4 26 27 28 29 30 ADJUSTMENT FOR PHYSICAL THERAPY PHYSICAL THERAPY A-8-3/A-8-4 ADJUSTMENT FOR HHA PHYSICAL THERAPY 89 UTILIZATION REVIEW-PHYSIAN COMP \*\*COST CENTER DELETED\*\* \*\*COST CENTER DELETED\*\*
\*\*COST CENTER DELETED\*\* DEPRECIATION-OLD BLDGS AND FIXTURES DEPRECIATION-OLD MOVABLE EQUIP 31 32 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E DEPRECIATION-NEW BLDGS AND FIXTURES DEPRECIATION-NEW MOVABLE EQUIP 33 34 35 NON-PHYSICIAN ANESTHETIST PHYSICIANS' ASSISTANT ADJUSTMENT FOR OCCUPATIONAL THERAPY NONPHYSICIAN ANESTHETISTS 20 A-8-4 \*\*COST CENTER DELETED\*\* 36 37 \*\*COST CENTER DELETED\*\* ADJUSTMENT FOR SPEECH PATHOLOGY 52 RENT INCOME
DR SPACE
IT MISC REVENUE -11,730 CLINIC 60 -5,120 -1,033 -7,804 -40 38 39 40 CLINIC 60 OTHER ADMINISTRATIVE AND 6.02 В LOBBYING HOSPITAL ONLY BUS OFF AND 6.01 CHILDBIRTH CLASSES В HOSPITAL ONLY BUS OFF AND 6.01 41 42 43 44 PHYS RECRUITMENT
ADVERTISING - HOSPITAL
ADVERTSING - BOWEN
ADVERTISING - CLINIC -3,061 HOSPITAL ONLY BUS OFF AND HOSPITAL ONLY BUS OFF AND 6.01 6.01 -51,166 -3,076 -10,494 RHC -BOWEN 63.50 45 CLINIC 60 MEDICAL SUPPLIES CHARGED 46 SUPPLIES SOLD -7,134 55 PROFESSIONL LIABILITY UNNECESSARY BORROWING 47 48 -103,476 -19,644 CLINIC NEW CAP REL COSTS-BLDG & 60 3.02 11 NURSING HOME MEALS BABY PICTURE REVENUE -79,858 -90 49 DIETARY 49.01 NURSERY 33 RENTAL INCOME - MIDWEST RENTAL INCOME MISC MISC INCOME -6,428 CLINIC HOSPITAL ONLY BUS OFF AND 49.02 60 -42,320 -8,754 -6,774 -3,600 6.01 49.03 49.04 HOSPITAL ONLY BUS OFF AND 6.01 В ADVERTISING - WOMENS RHC-WOMEN & FAMILY CLINIC RENTAL INCOME WOMEN'S CLINIC
MISC INCOME - PRAIRIE CARDIOVASCULAR
PURCHASE DISCOUNTS
MISC INCOME - GERO PHYS
PROVIDER TAX RHC-WOMEN & FAMILY CLINIC 49.06 63.51 49.07 -4,069 LABORATORY 44 49.08 HOSPITAL ONLY BUS OFF AND 6.01 -63,345 -351 49.09 GEO PSYCH HOSPITAL ONLY BUS OFF AND
HOSPITAL ONLY BUS OFF AND
OTHER LONG TERM CARE
HOSPITAL ONLY BUS OFF AND
HOSPITAL ONLY BUS OFF AND -168,153 6.01 49.10 49.11 CAPITAL CAMPAIGN FUND RAISING -3,868 6.01 49.14 49.15 MISC INCOME -15,915 36 MARKETING SALARIES MARKETING FRINGES 6.01 -53,359 -9,717 6.01 49.16 LINE OF CREDIT INTEREST
CITY OF CARTHAGE INTEREST
NURSING HOME DIETARY REVENUE
NURSING HOME LAUNDRY REVENUE
NURSING HOME SLF REVENUE HOSPITAL ONLY BUS OFF AND HOSPITAL ONLY BUS OFF AND OTHER LONG TERM CARE OTHER LONG TERM CARE OTHER LONG TERM CARE 49.17 -19,891 6.01 49.18 49.19 -24,308 6.01 36 -74,58049.20 -8,881 -7,686 49.22 49.23 49.24 NURSING HOME RENTAL INCOME -5.850 OTHER LONG TERM CARE 36 TOTAL (SUM OF LINES 1 THRU 49) -2,190,563

Description - all chapter references in this columnpertain to CMS Pub. 15-I.
 Basis for adjustment (see instructions).

 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

 Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7

Health Financial Systems MCR: STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND MCRIF32 HOME OFFICE COSTS

FOR MEMORIAL HOSPITAL ASSOCIATION

IN LIEU OF FORM CMS-2552-96(09/2000) I PROVIDER NO: I PERIOD: I
I 14-1305 I FROM 7/ 1/2009 I Ι

6/30/2010 I

PREPARED 11/23/2010 WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED

ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO. 1 1 8 2 3	COST CENTER 2 OPERATION OF PLANT	EXPENSE ITEMS 3 RENT	AMOUNT OF ALLOWABLE COST 4	AMOUNT 5 75,593	NET* ADJUST- MENTS 6 -75,593	WKSHT A-7 COL. REF.
4 5	TOTALS			75,593	-75,593	

\* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANI NAME	ZATION(S) AND/OR PERCENTAGE OF OWNERSHIP	HOME OFFICE TYPE OF BUSINESS
	1	2	3	4	5	6
1 2 3 4 5	Ċ	MEMORIAL HOSPITAL ASSOC.	0.00 0.00 0.00 0.00 0.00	HANCOCK COUNTY NURSING	100.00 0.00 0.00 0.00 0.00	SNF-NON-CERTIFIED

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP TO RELATED ORGANIZATIONS: A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
  - CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.

  - PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION. D.
  - INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
  - DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
    OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(9/1996)

I PROVIDER BASED PHYSICIAN ADJUSTMENTS
I 14-1305
I FROM 7/ 1/2009
I WORKSHEET A-8-2
I TO 6/30/2010
I GROUP 1

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 20 21 22 22 23 24 25 26 27 27 28 29 20 20 21 21 21 21 21 21 21 21 21 21 21 21 21	WKSH LINE 1 44 43 60 61 5 5	NO.  LABORATOR' RADIOISOTO CLINIC PH' ER FEES CLINIC EM	TOTAL REMUN- ERATION 3 18,000 4,500 1,037,686 788,342 79,056 2,539	PROFES- SIONAL COMPONENT 4 1,037,686 111,682 79,056 2,539	PROVIDER COMPONENT 5 18,000 4,500 676,660	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
29 30 101		TOTAL	1,930,123	1,230,963	699,160				

 Health Financial Systems
 MCRIF32
 FOR MEMORIAL HOSPITAL PROVIDER NO: 1 PROVIDER NO: 1

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	43 60 61 5	A O. LABORATORY RADIOISOTO CLINIC PHY ER FEES	PE SICIAN SALARIES LOYEE BENEFITS	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUSTMENT 18 1,037,686 111,682 79,056 2,539
21										
24 25 26										
24 25 26 27 28 29										
30 101		TOTAL								1,230,963

	PHYSICAL THER					
PART 1	I - GENERAL INFORMATION TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52				
2	(SEE INSTRUCTIONS) LINE 1 MULTIPLIED BY 15 HOURS PER WEEK NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	780				
4	(SEE INSTRUCTIONS) NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)					
5 6	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS) NUMBER OF UNDUPLICATED OFFSITE VISITS -					
	THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S))					
7 8	(SEE INSTRUCTIONS) STANDARD TRAVEL EXPENSE RATE OPTIONAL TRAVEL EXPENSE RATE PER MILE					
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
9	TOTAL HOURS WORKED	1	2 119.75	3	4 409.50	5
10 11	AHSEA (SEE INSTRUCTIONS) STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF	35.21	70.42 35.21		35.21	
12	COLUMN 3, LINE 10) NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS) NUMBER OF MILES DRIVEN					
13.01	(SEE INSTRUCTIONS) NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					
PART 14	II - SALARY EQUIVALENCY COMPUTATION SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)					
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	8,433				
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	0.433				
17 18	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS )	8,433				
19	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10) TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	14,418				
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	22,851				
THE	THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY RAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRI ERWISE COMPLETE LINES 21-23.	ES ON LINES 21	FOR PHYSICAL L AND 22 AND	L THERAPY, SPE ENTER ON LINE	ECH PATHOLOGY 23 THE AMOUNT	OR OCCUPATIONAL FROM LINE 20.
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)					
22 23	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	54,928				
	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)  III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAV	69,346	ADUTATION - P	POVIDER SITE		
	NDARD TRAVEL ALLOWANCE THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	,	a orange			
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)					
26 27	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)					
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)					
ОРТ 29	TONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)					
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)					
31 32	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS) OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)					

Health Financial Systems MCRTF32 IN LIEU OF FORM CMS-2552-96(12/1999) FOR MEMORIAL HOSPITAL ASSOCIATION I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-8-4
I TO 6/30/2010 I PARTS I - VII REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PHYSICAL THERAPY STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL 33 34 35

EXPENSE (SUM OF LINES 31 AND 32) PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD TRAVEL EXPENSE

36 THERAPISTS (LINE 5 TIMES COLUMN 2,

LINE 11)
ASSISTANTS (LINE 6 TIMES COLUMN 3, 37 LINE 11)

SUBTOTAL (SUM OF LINES 36 AND 37)

- 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)
  THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
  ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, 40
- 41

LINE 10)

LINE 10)

SUBTOTAL (SUM OF LINES 40 AND 41)

OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;

COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL

EXPENSE (SUM OF LINES 38 AND 39 -

SEE INSTRUCTIONS)

OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 -45

SEE INSTRUCTIONS)
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
EXPENSE (SUM OF LINES 42 AND 43 -46 SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

		THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
		1	2	3	4	5
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5. LINE 47. IS ZERO OR FOUAL TO OR GREATER					

THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56) OVERTIME RATE (SEE INSTRUCTIONS)

CALCULATION OF LIMIT
TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48) 49

PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)
ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE 100.00 50 100.00

51 FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)

- DETERMINATION OF OVERTIME ALLOWANCE
  ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE 52 INSTRUCTIONS)
- OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)
- 54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)
- PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY 55 COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES
- 56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT
57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 69,346
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM

- PART III, LINE 33, 34, OR 35)
  TRAVEL ALLOWANCE AND EXPENSE PROVIDER SITE (FI
  TRAVEL ALLOWANCE AND EXPENSE OFFSITE SERVICES
  (FROM PART IV, LINES 44, 45, OR 46)
  OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)
  EQUIPMENT COST (SEE INSTRUCTIONS) 59
- 60 61
- SUPPLIES (SEE INSTRUCTIONS)
  - 69,346
- TOTAL ALLOWANCE (SUM OF LINES 57-62)
  TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR 63 30,905 RECORDS)

IN LIEU OF FORM CMS-2552-96(12/1999) Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-8-4
I TO 6/30/2010 I PARTS I - VII REASONABLE COST DETERMINATION FOR THERAPY

1.000000

SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

PHYSICAL THERAPY

EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS) 65

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66 COST OF OUTSIDE SUPPLIER SERVICES - 30,905

(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS 30,905
LINE MUST AGREE WITH LINE 64)

RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST— (LINE 66 DIVIDED BY LINE 67)
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST—FOR I (LINE 66 DIVIDED BY LINE 67)
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST—HHA I (LINE 66 DIVIDED BY LINE 67)
69 EXCESS COST OVER LIMITATION— (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
69.01 EXCESS COST OVER LIMITATION—CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
69.31 EXCESS COST OVER LIMITATION—HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE

TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(12/1999)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

REASONABLE COST DETERMINATION FOR THERAPY I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-8-4

SERVICES FURNISHED BY OUTSIDE SUPPLIERS I TO 6/30/2010 I PARTS I - VII

ON OR AFTER APRIL 10, 1998

OCCUPATIONAL THERAPY

PART 1	I - GENERAL INFORMATION TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52				
3	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	780				
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					
5	(SEE INSTRUCTIONS) NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)					
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR					•
7 8	THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS) STANDARD TRAVEL EXPENSE RATE OPTIONAL TRAVEL EXPENSE RATE PER MILE					
•		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
9	TOTAL HOURS WORKED	1	75.75	3	4 241.50	5
10 11	TOTAL HOURS WORKED AHSEA (SEE INSTRUCTIONS) STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF	33.37	66.74 33.37		33.37	
12	COLUMN 3, LINE 10) NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS) L NUMBER OF MILES DRIVEN OFFSITE					
13.0.	(SEE INSTRUCTIONS)					
PART 14	II - SALARY EQUIVALENCY COMPUTATION SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)					
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	5,056				
16 17	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10) SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT	5,056				
18 19	OR LINES 14-16 FOR ALL OTHERS ) AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10) TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5,	8,059				
20	LINE 10) TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	13,115				
THI	THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY REPORTS. THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY REPORTS.	OR COLUMNS 1-3	3 FOR PHYSICA 1 AND 22 AND	L THERAPY, SPE ENTER ON LINE	ECH PATHOLOGY 23 THE AMOUNT	OR OCCUPATIONAL FROM LINE 20.
ОТI 21	HERWISE COMPLETE LINES 21-23. WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	66.75				
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	52,065				
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	60,124				
ST	III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAV	EL EXPENSE CO	MPUTATION - P	ROVIDER SITE		
24 25	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11) ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)					
26 27	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES					
28	3 AND 4) TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)					
OP <sup>.</sup> 29	26 AND 27) IIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF					
30	COLUMNS 1 AND 2, LINE 12) ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3,					
31	LINE 12) SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)					
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)					

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(12/1999)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

REASONABLE COST DETERMINATION FOR THERAPY I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-8-4

SERVICES FURNISHED BY OUTSIDE SUPPLIERS I I TO 6/30/2010 I PARTS I - VII

ON OR AFTER APRIL 10, 1998

OCCUPATIONAL THERAPY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL

EXPENSE (LINE 28)

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STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30) OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)
34
35
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE
   STANDARD TRAVEL EXPENSE
THERAPISTS (LINE 5 TIMES COLUMN 2,
36
          LINE 11)
          ASSISTANTS (LINE 6 TIMES COLUMN 3,
37
          LINE 11)
          SUBTOTAL (SUM OF LINES 36 AND 37)
STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF
38
39
          LINES 5 AND 6)
THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES
COLUMN 2, LINE 10)
ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3,
LINE 10)
40
41
          SUBTOTAL (SUM OF LINES 40 AND 41)
OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF
          CQLUMNS 1-3, LINE 13)
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
```

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL
	EXPENSE (SUM OF LINES 38 AND 39 -
	SEE INSTRUCTIONS)
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
	EXPENSE (SUM OF LINES 39 AND 42 -
	SEE INSTRUCTIONS)
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
	EXPENSE (SUM OF LINES 42 AND 43 ~
	SEE INSTRUCTIONS)

PART	V - OVERTIME COMPUTATION	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
		1	2	3	4	5
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)	_				
48	OVERTIME RATE (SEE INSTRUCTIONS)					
	CULATION OF LIMIT					
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DE.	FERMINATION OF OVERTIME ALLOWANCE					
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE					
	INSTRUCTIONS)					
53	OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54	MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					

J-7	OR LINE 53)	
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY	
	COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES	
	LINE 52)	
56	OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF	
	NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF	
	COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND	
	COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)	
DADT	VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST	ADJUSTMENT
57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	60.124
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM	00,12.
-	PART III. LINE 33, 34. OR 35)	
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	
	(FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	60,124
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR	18,585
	RECORDS)	

IN LIEU OF FORM CMS-2552-96(12/1999) Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-8-4
I TO 6/30/2010 I PARTS I - VII REASONABLE COST DETERMINATION FOR THERAPY

SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

OCCUPATIONAL THERAPY

EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS) 65

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS 18,585 LINE MUST AGREE WITH LINE 64)

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO 1.000000 TOTAL COST- (LINE 66 DIVIDED BY LINE 67)

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
69 EXCESS COST OVER LIMITATION(SEE INSTRUCTIONS) (TRANSEED TO MINET A.8 LINES

(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
69.01 EXCESS COST OVER LIMITATION-CORF I

(SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

69.31 EXCESS COST OVER LIMITATION- HHA I
(SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(7/2009)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

I FROM 7/ 1/2009 I NOT A CMS WORKSHEET

I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	ENERAL SERVICE COST	31111211112 0002	51711.251.245 52551.41 1.251.	
3	NEW CAP REL COSTS-BLDG & FIXT	3	OLD HOSP/PBC SQUARE	ENTERED
3.01	NEW CAP REL COSTS-NH BLDG	4	NH/MSS SQUARE FEET	ENTERED
3.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	23	NEW HOSP SQUARE FE	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	5	HOSP SQUARE FEET	ENTERED
4.01	NEW CAP REL COSTS-NH ME	6 12 24	NH SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	12	HOSPITAL SALARIES	ENTERED
5.01	SHARED HUMAN RESOURCES	24	HOSP/NH GROSS SAL	ENTERED
6.01	HOSPITAL ONLY BUS OFF AND A&G	25	HOSP ONLY ACCUM. COST	ENTERED
6.02	OTHER ADMINISTRATIVE AND GENERAL SHA	-8	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	10	HOSP ONLY SQUARE FT	ENTERED
8.01	OPERATION OF PLANT NURSING HOME	4	NH/MSS SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	11	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	10	HOSP ONLY SQUARE FT	ENTERED
10.01	HOUSEKEEPING NURSING HOME	4	NH/MSS SQUARE FEET	ENTERED
11	DIETARY	13	HOSP PATIENT DAYS	ENTERED
12	CAFETERIA	14	HOURS OF SERVICE	ENTERED
14	NURSING ADMINISTRATION	16	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	17	COSTED REQUIS.	NOT ENTERED
16	PHARMACY	18	COSTED REQUIS.	NOT ENTERED
17	MEDICAL RECORDS & LIBRARY	19	GROSS REVENUES	ENTERED
18	SOCIAL SERVICE	20	TIME SPENT	ENTERED
20	NONPHYSICIAN ANESTHETISTS	22	ASSIGNED TIME	ENTERED

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(7/2009)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

COST ALLOCATION - GENERAL SERVICE COSTS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET B

I TO 6/30/2010 I PART I

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-NH BLDG		NEW CAP REL C OSTS-MVBLE E		EMPLOYEE BENE FITS
		0	3	3.01	3.02	4	4.01	5
003 003 003 004 004	GENERAL SERVICE COST CNTR NEW CAP REL COSTS-BLDG & 01 NEW CAP REL COSTS-NH BLDG 02 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E 01 NEW CAP REL COSTS-NH ME EMPLOYEE BENEFITS	36,508 108,847 2,002,839 718,553 24,585 2,195,385	36,508	108,847	2,002,839	718,553	24,585	2,195,385
005 006 006 008	01 SHARED HUMAN RESOURCES 01 HOSPITAL ONLY BUS OFF AND 02 OTHER ADMINISTRATIVE AND OPERATION OF PLANT	85,460 1,251,879 1,089,986 629,367	9,716 2,282	9,018 9,583	481,076 99,249	177,223 37,919	2,643	17,884 157,556 247,437 41,466
008 009 010 010	01 OPERATION OF PLANT NURSIN LAUNDRY & LINEN SERVICE HOUSEKEEPING 01 HOUSEKEEPING NURSING HOME	340,163 50,501 147,851 95,398	498 60	5,432 279	8,581 21,534	4,745 6,099		453 29,892
011 012 014 015 016	DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	101,874 131,136 112,927	629 247 54		40,693 23,207 12,521	14,047 7,467 3,639		32,693 31,015 31,503
017 018 020	PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS INPAT ROUTINE SRVC CNTRS	222,197 16,165 313,332	2,673 54	2,491	37,185 8,257	23,086 2,489		51,751 4,996 91,793
025 026	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	1,192,096	2,530 95		461,920	136,945 466		362,959
033 036	NURSERY OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS	121,799 1,900,160		69,611	10,632	2,868	20,774	36,826
037 039 040	OPERATING ROOM DELIVERY ROOM & LABOR ROO ANESTHESIOLOGY	399,512 112,711	1,171 185		189,215 41,826	56,755 12,184		88,050 34,053
041 043 044	RADIOLOGY-DIAGNOSTIC RADIOISOTOPE LABORATORY	821,212 69,291 1,187,628	790		209,129 14,626 79,712	25,357		131,645 138,101
044 046 049 050	02 GEO PSYCH WHOLE BLOOD & PACKED RED RESPIRATORY THERAPY PHYSICAL THERAPY	267,826 60,744 218,685 52,404	3,566 170	2,670 1,010	32,651 12,251		279	16,886 48,293
053 055 056	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED DRUGS CHARGED TO PATIENTS	10,224 422,176 666,274	551 667 110	345 2,382	53,105 15,381 59,096	17,016 7,409	95	
060 061 062	OUTPAT SERVICE COST CNTRS CLINIC EMERGENCY OBSERVATION BEDS (NON-DIS	655,795 980,700			87,484	36,798 25,677		126,596 142,604
063 063 063 063	OTHER OUTPATIENT SERVICE 01 DIABETIC EDUCATION 50 RHC -BOWEN 51 RHC-WOMEN & FAMILY CLINIC OTHER REIMBURS COST CNTRS AMBULANCE SERVICES					3,362		11,168 44,534 155,163
095	SPEC PURPOSE COST CENTERS SUBTOTALS NONREIMBURS COST CENTERS	19,893,399	36,037	102,821	1,999,331	715,307	24,448	2,132,293
096 098 100	GIFT, FLOWER, COFFEE SHOP PHYSICIANS' PRIVATE OFFIC NAUVOO APARTMENTS			5,529	3,508	1,790 1,456		63,092
100 101 102	01 BEAUTY SHOP CROSS FOOT ADJUSTMENT NEGATIVE COST CENTER	8,758		497			137	,
103	TOTAL	20,210,194	36,508	108,847	2,002,839	718,553	24,585	2,195,385

IATION IN LIEU OF FORM CMS-2552-96(7/2009)CONTD

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET B
I TO 6/30/2010 I PART I Health Financial Systems FOR MEMORIAL HOSPITAL ASSOCIATION MCRIF32

COST ALLOCATION - GENERAL SERVICE COSTS

	COST CENTER DESCRIPTION	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND	SUBTOTAL	OTHER ADMINIS TRATIVE AND	OPERATION OF PLANT	OPERATION OF PLANT NURSIN	LAUNDRY & LIN EN SERVICE
	orbeith 12011	5.01	6.01	6a.01	6.02	8	8.01	9
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003	01 NEW CAP REL COSTS-NH BLDG							
003 004	02 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E							
004	01 NEW CAP REL COSTS-NH ME							
005	EMPLOYEE BENEFITS							
005	01 SHARED HUMAN RESOURCES	103,344						
006	01 HOSPITAL ONLY BUS OFF AND		2,092,815					
006	02 OTHER ADMINISTRATIVE AND	10,314	181,952	1,541,915		006 760		
800	OPERATION OF PLANT	1,670	108,769	920,722	76,047	996,769	375,266	
008 009	01 OPERATION OF PLANT NURSIN LAUNDRY & LINEN SERVICE	1,041 18	8,681	346,636 73,477	28,630 6,069	10,744	3/3,200	90,290
010	HOUSEKEEPING	1,204	27,676	234,316		13,809		***************************************
010	01 HOUSEKEEPING NURSING HOME		27,070	96,771			1,236	
011	DIETARY	1,317	25,644	216,897		31,804	•	375
012	CAFETERIA	1,249	26,030	220,351	18,200	16,907		1,363
014	NURSING ADMINISTRATION	1,269	21,680	183,593	15,164	8,239		
015	CENTRAL SERVICES & SUPPLY	•						
016	PHARMACY	2 005	45 737	207 205	21 001	26,399	11,023	
017 018	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	2,085 201	45,737 4,314	387,205 36,476		5,636	11,023	•
020	NONPHYSICIAN ANESTHETISTS		54,697	463,520		3,030		
020	INPAT ROUTINE SRVC CNTRS	3,030	34,037	403,320	30,20			
025	ADULTS & PEDIATRICS	14,626	294,072	2,465,148	203,618	310,065		46,412
026	INTENSIVE CARE UNIT		75	636	53	1,055		
033	NURSERY	1,483	21,421	195,029		6,493		
036	OTHER LONG TERM CARE	13,051		2,003,596	165,487		307,994	
027	ANCILLARY SRVC COST CNTRS		00 021	077 201	60 155	120 502		15,852
037 039	OPERATING ROOM	3,547	99,031	837,281 229,458				13,632
040	DELIVERY ROOM & LABOR ROO ANESTHESIOLOGY	1,372	27,127	229,430	10,932	27,303		
041	RADIOLOGY-DIAGNOSTIC	5,303	164,994	1,396,070	115,308	141,586		10,935
043	RADIOISOTOPE	3,303	11,846	100,233				
044	LABORATORY	5,563	192,388	1,629,539	134,592	55,369		687
044	02 GEO PSYCH	680	40,991	347,373		4,944		
046	WHOLE BLOOD & PACKED RED		8,127	68,871		21 010	11 013	1 420
049	RESPIRATORY THERAPY	1,945	42,656	356,706			11,813 4,471	
050	PHYSICAL THERAPY	96	7,184	76,432 94,951				•
053 055	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED	367	11,577 60,971	516,527				
056	DRUGS CHARGED TO PATIENTS			898,392				
030	OUTPAT SERVICE COST CNTRS		200,002	000,000	, .,			
060	CLINIC	5,100	110,148	941,969				1,075
061	EMERGENCY	5,744	166,374	1,409,009	116,377	58,137		10,957
062	OBSERVATION BEDS (NON-DIS	;						
063	OTHER OUTPATIENT SERVICE	450	7 224	62.064	E 126			
063 063	01 DIABETIC EDUCATION 50 RHC -BOWEN	450 1,794	7,324 35,107	62,064 297,504				201
063	51 RHC-WOMEN & FAMILY CLINIC		144,292	1,129,773				828
003	OTHER REIMBURS COST CNTRS		144,232	1,123,773	33,32,			
065	AMBULANCE SERVICES	•						
	SPEC PURPOSE COST CENTERS	<b>;</b>						
095	SUBTOTALS	100,710	2,056,970	19,778,440	1,506,254	988,463	348,605	90,115
	NONREIMBURS COST CENTERS	_				4 054		
096	GIFT, FLOWER, COFFEE SHOP		737	6,208				!
098 100	PHYSICIANS' PRIVATE OFFICE NAUVOO APARTMENTS	2,542	35,108	390,514 25,548				175
100	01 BEAUTY SHOP	92		23,346 9,484			2,199	
101	CROSS FOOT ADJUSTMENT	32		J₁707			_,	
102	NEGATIVE COST CENTER							
103	TOTAL	103,344	2,092,815	20,210,194	1,541,915	996,769	375,266	90,290

IN LIEU OF FORM CMS-2552-96(7/2009)CONTD
R NO: I PERIOD: I PREPARED 11/23/2010
I FROM 7/ 1/2009 I WORKSHEET B
I TO 6/30/2010 I PART I Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION PROVIDER NO: COST ALLOCATION - GENERAL SERVICE COSTS 14-1305

NURSING ADMIN CENTRAL SERVI PHARMACY HOUSEKEEPING HOUSEKEEPING DIETARY CAFETERIA CES & SUPPLY ISTRATION COST CENTER NURSING HOME DESCRIPTION 12 15 16 10 10.01 11 GENERAL SERVICE COST CNTR NEW CAP REL COSTS-BLDG & O1 NEW CAP REL COSTS-NH BLDG O2 NEW CAP REL COSTS-BLDG & 003 003 003 NEW CAP REL COSTS-BLDG &
NEW CAP REL COSTS-MVBLE E
O1 NEW CAP REL COSTS-NH ME
EMPLOYEE BENEFITS
O1 SHARED HUMAN RESOURCES 004 005 005 006 01 HOSPITAL ONLY BUS OFF AND 006 02 OTHER ADMINISTRATIVE AND OPERATION OF PLANT
01 OPERATION OF PLANT NURSIN
LAUNDRY & LINEN SERVICE 800 008 009 010 HOUSEKEEPING 267,478 01 HOUSEKEEPING NURSING HOME 010 106,000 8,750 275,741 011 DIETARY CAFETERIA 261,473 012 014 4,652 NURSING ADMINISTRATION 215,792 6,529 015 CENTRAL SERVICES & SUPPLY 016 PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS 18,970 017 7,263 3,124 1,742 1,905 3,174 018 1,551 020 2,902 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS INTENSIVE CARE UNIT 71,366 025 85,306 275,540 78,040 026 290 201 7,367 1.786 8,056 033 NURSERY 036 OTHER LONG TERM CARE 87,285 ANCILLARY SRVC COST CNTRS OPERATING ROOM 17,109 037 35,354 18,709 DELIVERY ROOM & LABOR ROO 6,812 039 7,589 7,449 ANESTHESIOLOGY 040 041 RADIOLOGY-DIAGNOSTIC 38,953 27,013 24,702 043 RADIOISOTOPE 33,952 31.048 044 044 LABORATORY 02 GEO PSYCH 15,233 6,030 1,360 6.594 046 WHOLE BLOOD & PACKED RED 049 RESPIRATORY THERAPY 6,003 13,281 12.145 3,348 PHYSICAL THERAPY
ELECTROCARDIOLOGY
MEDICAL SUPPLIES CHARGED
DRUGS CHARGED TO PATIENTS
OUTPAT SERVICE COST CNTRS 050 2,058 1,267 053 10,600 2,573 2,353 055 4,615 9,974 056 2,987 6,393 6,990 2,865 15,995 060 CLINIC 23,578 **EMERGENCY** 25,783 061 062 OBSERVATION BEDS (NON-DIS OTHER OUTPATIENT SERVICE 063 063 01 DIABETIC EDUCATION 2,455 2,245 50 RHC -BOWEN 51 RHC-WOMEN & FAMILY CLINIC OTHER REIMBURS COST CNTRS 063 063 065 AMBULANCE SERVICES SPEC PURPOSE COST CENTERS 215.792 SUBTOTALS NONREIMBURS COST CENTERS 265,193 275,741 261,473 095 98,444 NONREIMBURS COST CENTERS
GIFT, FLOWER, COFFEE SHOP
PHYSICIANS' PRIVATE OFFIC
NAUVOO APARTMENTS
01 BEAUTY SHOP
CROSS FOOT ADJUSTMENT 096 1.115 098 6,933 100 100 623

275,741

261,473

215.792

101 102

103

NEGATIVE COST CENTER

267,478

106,000

COST ALLOCATION - GENERAL SERVICE COSTS

		MEDICAL RECOR DS & LIBRARY		NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP- DOWN ADJ	TOTAL
	DESCRIPTION	17	18	20	25	26	27
003 003 003 004 004 005	GENERAL SERVICE COST CNTR NEW CAP REL COSTS-BLDG & 01 NEW CAP REL COSTS-NH BLDG 02 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E 01 NEW CAP REL COSTS-NH ME EMPLOYEE BENEFITS	1/		20	.,	20	<u>.</u> ,
005	01 SHARED HUMAN RESOURCES						
006	01 HOSPITAL ONLY BUS OFF AND						
006	02 OTHER ADMINISTRATIVE AND						
800	OPERATION OF PLANT						
008 009	01 OPERATION OF PLANT NURSIN LAUNDRY & LINEN SERVICE						
010	HOUSEKEEPING						
010	01 HOUSEKEEPING NURSING HOME						
011	DIETARY						
012	CAFETERIA						
014	NURSING ADMINISTRATION						
015 016	CENTRAL SERVICES & SUPPLY PHARMACY						
017	MEDICAL RECORDS & LIBRARY	485,965					
018	SOCIAL SERVICE	403,303	50,323	}			
020	NONPHYSICIAN ANESTHETISTS		**,	507,880			
	INPAT ROUTINE SRVC CNTRS						2 520 522
025	ADULTS & PEDIATRICS	43,105	50,323	i	3,628,923		3,628,923 2,304
026 033	INTENSIVE CARE UNIT NURSERY	69 1,273			2,304 236,112		236,112
036	OTHER LONG TERM CARE	1,2/3			2,564,362		2,564,362
	ANCILLARY SRVC COST CNTRS				-,,		, .
037	OPERATING ROOM	23,593			1,145,555		1,145,555
039	DELIVERY ROOM & LABOR ROO	1,429			299,274		299,274
040	ANESTHESIOLOGY	17,212		507,880			525,092 1,847,821
041 043	RADIOLOGY-DIAGNOSTIC RADIOISOTOPE	93,254 8,325			1,847,821 129,486		129,486
044	LABORATORY	91,176			1,991,596		1,991,596
044	02 GEO PSYCH	6,776		,	401,768		401,768
046	WHOLE BLOOD & PACKED RED	1,434			75,993		75,993
049	RESPIRATORY THERAPY	10,362			466,368		466,368
050	PHYSICAL THERAPY	2,282			100,304 158,962		100,304 158,962
053 055	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED	7,042 21,750			609,216		609,216
056	DRUGS CHARGED TO PATIENTS	26,932			1,072,665		1,072,665
	OUTPAT SERVICE COST CNTRS	,					
060	CLINIC	5,555			1,039,681		1,039,681
061	EMERGENCY	24,044			1,683,880		1,683,880
062 063	OBSERVATION BEDS (NON-DIS OTHER OUTPATIENT SERVICE						•
063	01 DIABETIC EDUCATION	351			72,241		72,241
063	50 RHC -BOWEN	5.603			327,880		327,880
063	51 RHC-WOMEN & FAMILY CLINIC	15,608			1,239,523		1,239,523
065	OTHER REIMBURS COST CNTRS AMBULANCE SERVICES SPEC PURPOSE COST CENTERS						
095	SUBTOTALS NONREIMBURS COST CENTERS	407,175	50,32	507,880	19,619,006		19,619,006
096	GIFT, FLOWER, COFFEE SHOP				11,890	,	11,890
098	PHYSICIANS' PRIVATE OFFIC	78,790			537,157	•	537,157
100	NAUVOO APARTMENTS				29,052		29,052
100	01 BEAUTY SHOP				13,089		13,089
101 102	CROSS FOOT ADJUSTMENT NEGATIVE COST CENTER						
103	TOTAL	485,965	50,32	507,880	20,210,194		20,210,194
			•				

IATION IN LIEU OF FORM CMS-2552-96(7/2009)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET B
I TO 6/30/2010 I PART III Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION

ALLOCATION OF NEW CAPITAL RELATED COSTS

		COST CENTER NEW	ASSGNED NEW CAP F CAPITAL OSTS-BLDG L COSTS			NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E		SUBTOTAL
		DESCRIPTION RE	0 3		3.01	3.02	4	4.01	4a
003 003 003 004 004	01 02	GENERAL SERVICE COST CNTR NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-NH BLDG NEW CAP REL COSTS-NH BLDG & NEW CAP REL COSTS-MVBLE E NEW CAP REL COSTS-NH ME							
005		EMPLOYEE BENEFITS							
005		SHARED HUMAN RESOURCES							
006 006		HOSPITAL ONLY BUS OFF AND OTHER ADMINISTRATIVE AND	9,	716	9,018 9,583	481,076	177,223	2,643	677,033 12,226
008		OPERATION OF PLANT	2.	282	3,305	99,249	37,919	· ·	139,450
008		OPERATION OF PLANT NURSIN			5,432		,		5,432
009		LAUNDRY & LINEN SERVICE		498	•	8,581	4,745		13,824
010		HOUSEKEEPING		60		21,534	6,099		27,693
010	01	HOUSEKEEPING NURSING HOME			279				279
011		DIETARY		629		40,693	14,047		55,369
012		CAFETERIA		247		23,207	7,467		30,921
014		NURSING ADMINISTRATION		54		12,521	3,639		16,214
015 016		CENTRAL SERVICES & SUPPLY PHARMACY							
017		MEDICAL RECORDS & LIBRARY	2	673	2,491	37.185	23.086		65,435
018		SOCIAL SERVICE		54	-,	8,257	2,489		10,800
020		NONPHYSICIAN ANESTHETISTS		• .		-, -	•		
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	2	,530		461,920	136,945		601,395
026		INTENSIVE CARE UNIT		95			466		561
033		NURSERY				10,632	2,868		13,500
036		OTHER LONG TERM CARE			69,611			20,774	90,385
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	1	,171		189,215	56,755		247,141
039		DELIVERY ROOM & LABOR ROO		185		41,826	12,184		54,195
040		ANESTHESIOLOGY							272 016
041		RADIOLOGY-DIAGNOSTIC	1	, 254		209,129	62,533		272,916
043		RADIOISOTOPE		89		14,626	4,381		19,096
044		LABORATORY	_	790		79,712	25,357		105,859 20,990
044	02	GEO PSYCH	3	, 566			17,424		20,990
046		WHOLE BLOOD & PACKED RED		170	2 670	22 651	9,636		45,127
049		RESPIRATORY THERAPY		170	2,670	32,651 12,251	3,304	279	16,844
050		PHYSICAL THERAPY		FF1	1,010	53,105	17,016	213	70,672
053		ELECTROCARDIOLOGY		551	345	15,381	7,409	95	23,897
055 056		MEDICAL SUPPLIES CHARGED DRUGS CHARGED TO PATIENTS		667 110	2,382	59,096	16,478	657	78.723
030		OUTPAT SERVICE COST CNTRS		110	2,302	33,030	20,470	05.	, , , , , ,
060		CLINIC	7	.532			36,798		44,330
061		EMERGENCY	•	426		87,484	25,677		113,587
062		OBSERVATION BEDS (NON-DIS				***	- •		
063		OTHER OUTPATIENT SERVICE							
063	01	DIABETIC EDUCATION		688			3,362		4,050
063	50	RHC -BOWEN							
063	51	RHC-WOMEN & FAMILY CLINIC							
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES							
		SPEC PURPOSE COST CENTERS		037	102 221	1 000 331	715 207	24 440	2,877,944
095		SUBTOTALS	36	,037	102,821	1,999,331	715,307	24,448	2,017,344
000		NONREIMBURS COST CENTERS		170		3 500	1,790		5,471
096 098		GIFT, FLOWER, COFFEE SHOP		173 298	5,529	3,508	1,790		7,283
100		PHYSICIANS' PRIVATE OFFIC NAUVOO APARTMENTS		4.70	3,329		1,430		.,
100	01	BEAUTY SHOP			497			137	634
101	71	CROSS FOOT ADJUSTMENTS			731				
102		NEGATIVE COST CENTER							
103		TOTAL	36	, 508	108,847	2,002,839	718,553	24,585	2,891,332
			30		,			•	

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(7/2009)CONTD

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

ALLOCATION OF NEW CAPITAL RELATED COSTS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET B

I TO 6/30/2010 I PART III

	COST CENTER	EMPLOYEE FITS	BENE	SHARED HUMAN RESOURCES		OTHER ADMINIS TRATIVE AND	OPERATION OF PLANT	OPERATION OF PLANT NURSIN	LAUNDRY & LIN EN SERVICE
	DESCRIPTION	_					•	0.01	•
	GENERAL SERVICE COST CNT	. 5		5.01	6.01	6.02	8	8.01	9
003	NEW CAP REL COSTS-BLDG &								
003	01 NEW CAP REL COSTS-NH BLD								
003	02 NEW CAP REL COSTS-BLDG &								
004	NEW CAP REL COSTS-MVBLE	E							
004	01 NEW CAP REL COSTS-NH ME								
005	EMPLOYEE BENEFITS								
005	01 SHARED HUMAN RESOURCES	-			677 633				
006 006	01 HOSPITAL ONLY BUS OFF AN 02 OTHER ADMINISTRATIVE AND				677,033 58,862	71,088			
008	OPERATION OF PLANT	,			35,187	3,506	178,143		
008	01 OPERATION OF PLANT NURSI	N			33,107	1,320	110,115	6,752	
009	LAUNDRY & LINEN SERVICE				2,808	280	1,920	-,	18,832
010	HOUSEKEEPING				8,953	892	2,468		·
010	01 HOUSEKEEPING NURSING HOM	IE			•	369		22	
011	DIETARY				8,296	826	5,684		78
012	CAFETERIA				8,421	839	3,022		284
014 015	NURSING ADMINISTRATION				7,013	699	1,473		
016	CENTRAL SERVICES & SUPPL PHARMACY	, Υ							
017	MEDICAL RECORDS & LIBRAR	· <b>v</b>			14,796	1,474	4,718	198	
018	SOCIAL SERVICE	••			1,396	139	1,007	130	
020	NONPHYSICIAN ANESTHETIST	'S			17,695	1,765			
	INPAT ROUTINE SRVC CNTRS					•			
025	ADULTS & PEDIATRICS				95,136	9,387	55,416		9,681
026	INTENSIVE CARE UNIT				24	2	188		
033	NURSERY				6,930	743	1,160	5,542	
036	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTR					7,630		3,342	
037	OPERATING ROOM	3			32,037	3,188	22,966		3,306
039	DELIVERY ROOM & LABOR RO	10			8,776	874	4,930		3,500
040	ANESTHESIOLOGY				0,110	• • • • • • • • • • • • • • • • • • • •	.,,		
041	RADIOLOGY-DIAGNOSTIC				53,376	5,316	25,304		2,281
043	RADIOISOTOPE				3,832	382	1,773		
044	LABORATORY				62,238	6,205	9,896		143
044 046	02 GEO PSYCH				13,261	1,323	884		
049	WHOLE BLOOD & PACKED RED RESPIRATORY THERAPY	,			2,629 13,799	262 1,358	3,899	213	298
050	PHYSICAL THERAPY				2,324	291	1,337	80	230
053	ELECTROCARDIOLOGY				3,745	362	6,886	•••	
055	MEDICAL SUPPLIES CHARGED	)			19,724	1,967	2,998	27	
056	DRUGS CHARGED TO PATIENT				34,319	3,421	6,479	190	
	OUTPAT SERVICE COST CNTR	ts.							224
060 061	CLINIC				35,633	3,587	1,861		224 2,285
062	EMERGENCY OBSERVATION BEDS (NON-DI				53,822	5,366	10,390		2,203
063	OTHER OUTPATIENT SERVICE								
063	01 DIABETIC EDUCATION	•			2,369	236			
063	50 RHC -BOWEN				11,357	1,133			42
063	51 RHC-WOMEN & FAMILY CLINI	c			46,679	4,302			173
	OTHER REIMBURS COST CNTR	ts.							
065	AMBULANCE SERVICES								
095	SPEC PURPOSE COST CENTER SUBTOTALS	(5			665,437	69,444	176,659	6,272	18,795
033	NONREIMBURS COST CENTERS				003,437	03,444	170,039	0,272	10,733
096	GIFT, FLOWER, COFFEE SHO				238	24	724		
098	PHYSICIANS' PRIVATE OFFI				11,358	1,487	589	440	
100	NAUVOO APARTMENTS				,	97	171		37
100	01 BEAUTY SHOP					36		40	
101	CROSS FOOT ADJUSTMENTS								
102 103	NEGATIVE COST CENTER TOTAL				677 022	71 000	170 1/3	6,752	18,832
102	TOTAL				677,033	71,088	178,143	0,732	10,032

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(7/2009)CONTD

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

ALLOCATION OF NEW CAPITAL RELATED COSTS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET B

I TO 6/30/2010 I PART III

NURSING ADMIN CENTRAL SERVI PHARMACY HOUSEKEEPING HOUSEKEEPING DIETARY CAFETERIA CES & SUPPLY COST CENTER NURSING HOME ISTRATION DESCRIPTION 16 10 10.01 11 12 GENERAL SERVICE COST CNTR NEW CAP REL COSTS-BLDG &
01 NEW CAP REL COSTS-NH BLDG
02 NEW CAP REL COSTS-BLDG &
NEW CAP REL COSTS-MVBLE E 003 003 003 004 01 NEW CAP REL COSTS-NH ME EMPLOYEE BENEFITS
01 SHARED HUMAN RESOURCES
01 HOSPITAL ONLY BUS OFF AND
02 OTHER ADMINISTRATIVE AND 005 005 006 006 OPERATION OF PLANT
01 OPERATION OF PLANT NURSIN
LAUNDRY & LINEN SERVICE 008 009 HOUSEKEEPING 010 40,006 010 01 HOUSEKEEPING NURSING HOME 670 011 DIETARY 1,309 71,562 012 014 015 44,183 CAFETERIA 696 NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY 1,103 26,841 339 016 017 MEDICAL RECORDS & LIBRARY 1,086 20 3,206 SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS 217 **Q18** 232 322 536 361 020 INPAT ROUTINE SRVC CNTRS
ADULTS & PEDIATRICS 025 13,187 8,876 12,760 71,510 026 INTENSIVE CARE UNIT 267 1,361 916 NURSERY 033 OTHER LONG TERM CARE 036 551 ANCILLARY SRVC COST CNTRS OPERATING ROOM 037 3,161 2,128 DELIVERY ROOM & LABOR ROO ANESTHESIOLOGY 039 1,135 1,259 847 040 041 RADIOLOGY-DIAGNOSTIC 3,073 5,826 4,565 043 RADIOISOTOPE 408 3,862 044 LABORATORY 5,737 02 GEO PSYCH WHOLE BLOOD & PACKED RED RESPIRATORY THERAPY 044 046 203 1,114 750 049 2,244 1,511 898 21 050 PHYSICAL THERAPY 308 8 ELECTROCARDIOLOGY 053 1,585 MEDICAL SUPPLIES CHARGED DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS 293 055 690 435 795 056 1,492 19 1.181 060 429 CLINIC 4,357 2,933 061 **EMERGENCY** 2,392 OBSERVATION BEDS (NON-DIS OTHER OUTPATIENT SERVICE 062 063 063 01 DIABETIC EDUCATION 415 279 50 RHC -BOWEN
51 RHC-WOMEN & FAMILY CLINIC
OTHER REIMBURS COST CNTRS
AMBULANCE SERVICES 063 065 SPEC PURPOSE COST CENTERS 095 SUBTOTALS 39,664 622 71,562 44,183 26,841 NONREIMBURS COST CENTERS GIFT, FLOWER, COFFEE SHOP PHYSICIANS' PRIVATE OFFIC 096 167 098 44 136 100 NAUVOO APARTMENTS 100 01 BEAUTY SHOP 4 CROSS FOOT ADJUSTMENTS 101 102 **NEGATIVE COST CENTER** 44,183 26,841 103 TOTAL 40,006 670 71,562

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(7/2009)CONTD

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

ALLOCATION OF NEW CAPITAL RELATED COSTS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET B

I TO 6/30/2010 I PART III

		COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			17	18	20	25	26	27
		GENERAL SERVICE COST CNT	R.					
003		NEW CAP REL COSTS-BLDG &						
003		NEW CAP REL COSTS-NH BLD						
003	02	NEW CAP REL COSTS-BLDG &						
004		NEW CAP REL COSTS-MVBLE	E					
004 005	ΟŢ	NEW CAP REL COSTS-NH ME						
005	Λ1	EMPLOYEE BENEFITS						
005		SHARED HUMAN RESOURCES HOSPITAL ONLY BUS OFF AN	_					
006		OTHER ADMINISTRATIVE AND						
008	٧Z	OPERATION OF PLANT	•					
008	01	OPERATION OF PLANT NURSI	N					
009	-	LAUNDRY & LINEN SERVICE						
010		HOUSEKEEPING						
010	01	HOUSEKEEPING NURSING HOM	E					
011		DIETARY						
012		CAFETERIA						
014		NURSING ADMINISTRATION						
015		CENTRAL SERVICES & SUPPLY	Υ					
016		PHARMACY						
017 018		MEDICAL RECORDS & LIBRAR	y 90,933	14 113				
020		SOCIAL SERVICE NONPHYSICIAN ANESTHETIST	•	14,113	20.257			
020		INPAT ROUTINE SRVC CNTRS	3		20,357			
025		ADULTS & PEDIATRICS	8,064	14,113		899,525		899.525
026		INTENSIVE CARE UNIT	13	14,113		883		883
033		NURSERY	238			25,115		25.115
036		OTHER LONG TERM CARE				104,108		104,108
		ANCILLARY SRVC COST CNTR	5			·		
037		OPERATING ROOM	4,414			323,629		323,629
039		DELIVERY ROOM & LABOR RO				72,283		72,283
040		ANESTHESIOLOGY	3,220			3,220		3,220
041		RADIOLOGY-DIAGNOSTIC	17,463			390,120		390,120
043		RADIOISOTOPE	1,557			27,048		27,048 213,276
044 044	0.3	LABORATORY GEO PSYCH	17,058			213,276		39,793
044	U,Z	WHOLE BLOOD & PACKED RED	1,268 268			39,793 3,159		3,159
049		RESPIRATORY THERAPY	1,939			71,307		71,307
050		PHYSICAL THERAPY	427			21.619		21,619
053		ELECTROCARDIOLOGY	1,317			84,567		84,567
055		MEDICAL SUPPLIES CHARGED				54,103		54,103
056		DRUGS CHARGED TO PATIENT				131,658		131,658
		OUTPAT SERVICE COST CNTR						
060		CLINIC	1,039			87,103		87,103
061		EMERGENCY	4,498			199,630		199,630
062		OBSERVATION BEDS (NON-DI						
063	01	OTHER OUTPATIENT SERVICE				7 415		7 415
063 063		DIABETIC EDUCATION RHC -BOWEN	66 1,048			7,415 13,580		7,415 13,580
063		RHC-WOMEN & FAMILY CLINI				54,074		54,074
003	71	OTHER REIMBURS COST CNTR				34,074		31,071
065		AMBULANCE SERVICES	-					
		SPEC PURPOSE COST CENTER	S					
095		SUBTOTALS	76,192	14,113		2,827,215		2,827,215
		NONREIMBURS COST CENTERS		•		•		
096		GIFT, FLOWER, COFFEE SHO	Р			6,624		6,624
098		PHYSICIANS' PRIVATE OFFI	C 14,741			36,078		36,078
100	0.4	NAUVOO APARTMENTS				344		344 714
100	υŢ	BEAUTY SHOP			20 257	714		20,357
101 102		CROSS FOOT ADJUSTMENTS NEGATIVE COST CENTER		•	20,357	20,357		20,337
103		TOTAL	90.933	14,113	20,357	2,891,332		2,891,332
			30,333	17,113	20,337	-,002,002		-,

 Health Financial
 Systems
 MCRIF32
 FOR MEMORIAL
 HOSPITAL
 ASSOCIATION
 IN LIEU OF FORM CMS-2552-96(7/2009)
 CMS-2552-96(7/2009)

 COST ALLOCATION - STATISTICAL
 BASIS
 I PROVIDER NO: I PERIOD: I FROM 7/ 1/2009 I WORKSHEET B-1
 WORKSHEET B-1

	COST CENTER DESCRIPTION		EW CAP REL C STS-NH BLDG	NEW CAP REL C N OSTS-BLDG & O	EW CAP REL C N STS-MVBLE E O		C EMPLOYEE BENE FITS
		(OLD HOSP/PBC (I SQUARE )	NH/MSS SQUARE FEET )	(NEW HOSP SQUA(	HOSP SQUARE ( FEET )	NH SQUARE FEET	(HOSPITAL SALA )RIES )
		3	3.01	3.02	4	4.01	5
003 003 003 004 004	GENERAL SERVICE COST NEW CAP REL COSTS-BLD  O1 NEW CAP REL COSTS-NH  O2 NEW CAP REL COSTS-BLD NEW CAP REL COSTS-MVB  O1 NEW CAP REL COSTS-NH	12,253	52,999	37,111	49,364	43,403	
005 005	EMPLOYEE BENEFITS 01 SHARED HUMAN RESOURCE						7,103,847 57,868
006	01 HOSPITAL ONLY BUS OFF	3,261	4,391	8,914	12,175		509,822
006 008	02 OTHER ADMINISTRATIVE OPERATION OF PLANT	766	4,666	1,839	2,605	4,666	800,657 134,175
008	01 OPERATION OF PLANT NU		2,645				
009 010	LAUNDRY & LINEN SERVI HOUSEKEEPING	167 20		159 399	326 419		1,466 96,725
010		20	136				
011	DIETARY	211		754 430	965 513		105,787 100,358
012 014	CAFETERIA NURSING ADMINISTRATIO	83 18		232	250		101,937
015	CENTRAL SERVICES & SU						
016 017 018 020	PHARMACY MEDICAL RECORDS & LIB SOCIAL SERVICE NONPHYSICIAN ANESTHET	897 18	1,213	689 153	1,586 171		167,457 16,165 297,025
025	INPAT ROUTINE SRVC CN	940		0 FFO	9,408		1,174,474
026	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	849 32		8,559	32		
033	NURSERY		22.004	197	197	26 675	119,162
036	OTHER LONG TERM CARE ANCILLARY SRVC COST C		33,894			36,675	
037	OPERATING ROOM	393		3,506	3,899		284,914
039 040	DELIVERY ROOM & LABOR ANESTHESIOLOGY	62		775	837		110,189
041	RADIOLOGY-DIAGNOSTIC	421		3,875	4,296		425,977
043 044	RADIOISOTOPE LABORATORY	30 265		271 1,477	301 1,742		446,868
044	02 GEO PSYCH	1,197		-,	1,197		54,640
046 049	WHOLE BLOOD & PACKED RESPIRATORY THERAPY	57	1,300	605	662		156,266
050		<i>31</i>	492	227	227	492	
053 055	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHAR	185 224	168	984 285	1,169 509	168	7,708 29,499
056	DRUGS CHARGED TO PATI	37	1,160	1,095	1,132	1,160	147,159
060	OUTPAT SERVICE COST C	2 520			2,528		409,639
060 061		2,528 143		1,621	1,764		461,440
062							
063 063		231			231		36,136
063							144,102 502,078
063 065	OTHER REIMBURS COST C AMBULANCE SERVICES						302,076
095	SPEC PURPOSE COST CEN SUBTOTALS	12,095	50,065	37,046	49,141	43,161	6,899,693
	NONREIMBURS COST CENT						
096 098		58 100	2,692	65	123 100		204,154
100	NAUVOO APARTMENTS					242	,
100 101			242			242	
102	NEGATIVE COST CENTER						2 405 205
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	36,508	108,847	2,002,839	718,553	24,585	2,195,385
104	UNIT COST MULTIPLIER	2.979515		53.968877		.56643	
105	(WRKSHT B, PT I) COST TO BE ALLOCATED		2.053756		14.556215		.309042
	(WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER						
107	(WRKSHT B, PT II) COST TO BE ALLOCATED						
	(WRKSHT B, PART III						
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)						

	COST CENTER DESCRIPTION	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND	•	OTHER ADMINIS TRATIVE AND	OPERATION OF PLANT	*	LAUNDRY & LIN EN SERVICE
			RO(HOSP ONLY A	AC RECONCIL- ) IATION	( ACCUM. COST	(HOSP ONLY SQI )ARE FT	U(NH/MSS SQUARE ) FEET )	(POUNDS OF LAUNDRY )
003 003 003 004 004	GENERAL SERVICE COST NEW CAP REL COSTS-BLD O1 NEW CAP REL COSTS-NH O2 NEW CAP REL COSTS-BLD NEW CAP REL COSTS-MVB O1 NEW CAP REL COSTS-NH	5.01	6.01	6a.02	6.02	8	8.01	9
005 005 006 006 008 008	EMPLOYEE BENEFITS 01 SHARED HUMAN RESOURCE 01 HOSPITAL ONLY BUS OFF 02 OTHER ADMINISTRATIVE OPERATION OF PLANT 01 OPERATION OF PLANT NU LAUNDRY & LINEN SERVI	8,301,098 509,822 828,510 134,175 83,632 1,466	15,642,292 1,359,963 812,968 64,884	-1,541,915	18,668,279 920,722 346,636 73,477	30,244 326	41,297	87,690
010 010 011	HOUSEKEEPING 01 HOUSEKEEPING NURSING DIETARY	96,725 87,892 105,787	206,860 191,668		234,316 96,771 216,897	419 965	136	364
012 014 015 016	CAFETERIA NURSING ADMINISTRATIO CENTRAL SERVICES & SU PHARMACY	100,358 101,937	194,558 162,041		220,351 183,593	513 250		1,324
017 018 020	MEDICAL RECORDS & LIB SOCIAL SERVICE NONPHYSICIAN ANESTHET INPAT ROUTINE SRVC CN	167,457 16,165 297,025	341,848 32,247 408,823		387,205 36,476 463,520	801 171	1,213	
025 026 033 036	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NURSERY OTHER LONG TERM CARE	1,174,474 119,162 1,048,321	2,197,971 561 160,108		2,465,148 636 195,029 2,003,596	9,408 32 197	33,894	45,076
037 039	ANCILLARY SRVC COST C OPERATING ROOM DELIVERY ROOM & LABOR	284,914 110,189	740,184 202,758		837,281 229,458	3,899 837		15,396
040 041 043 044	ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC RADIOISOTOPE LABORATORY	425,977 446,868	1,233,215 88,537 1,437,965		1,396,070 100,233 1,629,539	4,296 301 1,680		10,620 667
044 046 049	02 GEO PSYCH WHOLE BLOOD & PACKED RESPIRATORY THERAPY	54,640 156,266	306,382 60,744 318,820		347,373 68,871 356,706	150 662	1,300	1,389
050 053 055 056	PHYSICAL THERAPY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHAR DRUGS CHARGED TO PATI	7,708 29,499 147,159	53,693 86,528 455,713 792,911		76,432 94,951 516,527 898,392	227 1,169 509 1,100	492 168 1,160	
060 061 062	OUTPAT SERVICE COST C CLINIC EMERGENCY OBSERVATION BEDS (NON	409,639 461,440	823,281 1,243,529		941,969 1,409,009	316 1,764		1,044 10,641
063 063 063 063	OTHER OUTPATIENT SERV 01 DIABETIC EDUCATION	36,136 144,102 502,078	54,741 262,397 1,078,477		62,064 297,504 1,129,773			195 804
065 095	OTHER REIMBURS COST C AMBULANCE SERVICES SPEC PURPOSE COST CEN SUBTOTALS	8,089,523	15,374,375	-1,541,915	18,236,525	29,992	38,363	87,520
096 098	NONREIMBURS COST CENT GIFT, FLOWER, COFFEE PHYSICIANS' PRIVATE O	204,154	5,507 262,410	-1,341,915	6,208 390,514	123 100	2,692	
100 100 101 102	01 BEAUTY SHOP CROSS FOOT ADJUSTMENT	7,421			25,548 9,484	29	242	170
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	103,344	2,092,815	2	1,541,915 .082595	996,769	375,266 9.087004	90,290
105	(WRKSHT B, PT I) COST TO BE ALLOCATED (WRKSHT B, PART II)	.01244		_	.002000	32.957578		1.029650
107	(WRKSHT B, PT II) COST TO BE ALLOCATED		677,033		71,088	178,143	6,752	18,832
108	(WRKSHT B, PART III UNIT COST MULTIPLIER (WRKSHT B, PT III)		.04328	2	.003808	5.890193	.163499	.214757

 Health Financial
 Systems
 MCRIF32
 FOR MEMORIAL HOSPITAL ROSPITAL HOSPITAL ASSOCIATION
 IN LIEU OF FORM CMS-2552-96(7/2009)CONTD
 CMS-2552-96(7/2009)CONTD

 1
 PROVIDER NO:
 I PERIOD:
 I PREPARED 11/23/2010

 1
 1 4-1305
 I FROM 7/ 1/2009
 I WORKSHEET B-1

 1
 1 6/30/2010
 I FROM 7/ 1/2009
 I FROM 7/ 1/2009

	COST CENTER	HOUSEKEEPING H	OUSEVEEDING D	TETADV	CAFETERIA	NURSING ADMI	N CENTRAL SE	DI/T DHADMACY	
	DESCRIPTION		URSING HOME	IETART	CAFETERIA	ISTRATION	CES & SUPP		
		(HOSP ONLY SQU( ARE FT )	NH/MSS SQUARE( FEET )		(HOURS OF SERVICE	(DIRECT )NRSING HRS	(COSTED) REQUIS.	(COSTED) REQUIS.	)
	CENERAL CENTER COST	10	10.01	11	12	14	15	16	
003 003 003 004 004 005 005 006 006 008	01 HOSPITAL ONLY BUS OFF 02 OTHER ADMINISTRATIVE OPERATION OF PLANT								
009	LAUNDRY & LINEN SERVI	22 122							
010 010	HOUSEKEEPING NURSING	29,499	41,161						
011	DIETARY	965	,	2,744	173 350				
012 014 015 016	CAFETERIA NURSING ADMINISTRATIO CENTRAL SERVICES & SU PHARMACY	513 250			173,256 4,326	156,360			
017 018 020	MEDICAL RECORDS & LIB SOCIAL SERVICE NONPHYSICIAN ANESTHET	801 171	1,213		12,570 1,262 2,103	1,262 2,103			
025	INPAT ROUTINE SRVC CN ADULTS & PEDIATRICS	9,408		2,742	51,711	51,711			
026 033	INTENSIVE CARE UNIT NURSERY	32 197		2	5,338	5,338			
036	OTHER LONG TERM CARE ANCILLARY SRVC COST C OPERATING ROOM	3,899	33,894		12,397	12,397			
037 039 040	DELIVERY ROOM & LABOR ANESTHESIOLOGY	837			4,936	4,936			
041 043	RADIOLOGY-DIAGNOSTIC RADIOISOTOPE	4,296 301			17,899	17,899			
044 044		1,680 150			22,497 4,369	22,497 4,369			
046 049 050	WHOLE BLOOD & PACKED RESPIRATORY THERAPY PHYSICAL THERAPY	662 227	1,300 492		8,800	8,800			
053	ELECTROCARDIOLOGY	1,169			1 705	1,705			
055 056	MEDICAL SUPPLIES CHAR DRUGS CHARGED TO PATI OUTPAT SERVICE COST C	509 1,100	168 1,160		1,705 4,632	4,632			
060 061 062	CLINIC EMERGENCY OBSERVATION BEDS (NON	316 1,764			17,084	17,084			
063	OTHER OUTPATIENT SERV 01 DIABETIC EDUCATION				1,627	1,627			
063 063 065	50 RHC -BOWEN 51 RHC-WOMEN & FAMILY CL OTHER REIMBURS COST C AMBULANCE SERVICES								
095	SPEC PURPOSE COST CEN SUBTOTALS	29,247	38,227	2,744	173,256	156,360			
096 098	NONREIMBURS COST CENT GIFT, FLOWER, COFFEE PHYSICIANS' PRIVATE O	123 100	2,692						
100	NAUVOO APARTMENTS	29							
100 101	01 BEAUTY SHOP CROSS FOOT ADJUSTMENT		242						
102 103	NEGATIVE COST CENTER COST TO BE ALLOCATED	267,478	106,000	275,741	261,473	215,792			
104	(WRKSHT B, PART I) UNIT COST MULTIPLIER (WRKSHT B, PT I)	9.067358	2.575253	100.488703	1.50917	1 1.38009	7		
105	COST TO BE ALLOCATED (WRKSHT B, PART II)	5.007556		100,400,03		1.55505			
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)			ř					
107	COST TO BE ALLOCATED (WRKSHT B, PART III	40,006	670	71,562	44,183	26,841			
108	UNIT COST MÚLTIPLIER (WRKSHT B, PT III)	1.356182	.016278	26.079446	.255010	6 .17166	2		

COST ALLOCATION - STATISTICAL BASIS

		COST CENTER DESCRIPTION	MEDICAL RECO		SERVIC	NONPHYSICIAN ANESTHETISTS	
			(GROSS REVENUES	(TIME )SPENT	:	(ASSIGNED )TIME	)
			17	18	3	20	
003 003 003 004 004 005 005 006 006 008	01 01 01 02	GENERAL SERVICE COST NEW CAP REL COSTS-BLD NEW CAP REL COSTS-NH NEW CAP REL COSTS-MVB NEW CAP REL COSTS-MVB NEW CAP REL COSTS-NH EMPLOYEE BENEFITS SHARED HUMAN RESOURCE HOSPITAL ONLY BUS OFF OTHER ADMINISTRATIVE OPERATION OF PLANT OPERATION OF PLANT NU	-		•		
009 010 010 011 012 014 015 016		LAUNDRY & LINEN SERVI HOUSEKEEPING HOUSEKEEPING NURSING DIETARY CAFETERIA NURSING ADMINISTRATIO CENTRAL SERVICES & SU PHARMACY	21 070 442				
017 018 020		MEDICAL RECORDS & LIB SOCIAL SERVICE NONPHYSICIAN ANESTHET	31,979,443		309	2,080	
		INPAT ROUTINE SRVC CN				,	
025		ADULTS & PEDIATRICS	2,836,584		309		
026 033		INTENSIVE CARE UNIT NURSERY	4,528 83,776				
036		OTHER LONG TERM CARE	05,110				
		ANCILLARY SRVC COST C					
037		OPERATING ROOM	1,552,597				
039 040		DELIVÉRY ROOM & LABOR ANESTHESIOLOGY	94,065 1,132,665			2,080	
041		RADIOLOGY-DIAGNOSTIC	6,136,425			2,000	
043		RADIOISOTOPE	547,810				
044		LABORATORY	6,000,008				
044	02	GEO PSYCH	445,919				
046		WHOLE BLOOD & PACKED	94,342				
049 050		RESPIRATORY THERAPY PHYSICAL THERAPY	681,876 150,197				
053		ELECTROCARDIOLOGY	463,408				
055		MEDICAL SUPPLIES CHAR	1,431,278				
056		DRUGS CHARGED TO PATI	1,772,303				
		OUTPAT SERVICE COST C					
060 061		CLINIC EMERGENCY	365,584				
062		OBSERVATION BEDS (NON	1,582,230				
063		OTHER OUTPATIENT SERV					
063	01	DIABETIC EDUCATION	23,083				
063		RHC -BOWEN	368,708				
063	эт	RHC-WOMEN & FAMILY CL OTHER REIMBURS COST C AMBULANCE SERVICES	1,027,118				
065		SPEC PURPOSE COST CEN					
095		SUBTOTALS	26,794,504		309	2,080	
		NONREIMBURS COST CENT					
096		GIFT, FLOWER, COFFEE	F 104 020				
098 100		PHYSICIANS' PRIVATE O NAUVOO APARTMENTS	5,184,939				
100	01	BEAUTY SHOP					
101		CROSS FOOT ADJUSTMENT					
102		NEGATIVE COST CENTER					
103		COST TO BE ALLOCATED	485,965	50	, 323	507,880	
104		(PER WRKSHT B, PART UNIT COST MULTIPLIER		167	.857605		
104		(WRKSHT B, PT I)	.01519		.007603	244.1730	77
105		COST TO BE ALLOCATED	.01313	-			•
		(PER WRKSHT B, PART					
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)					
107		COST TO BE ALLOCATED (PER WRKSHT B, PART	90,933	14	,113	20,357	
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)	.00284		.673139	9.7870	19

IN LIEU OF FORM CMS-2552-96(07/2009) Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C
I TO 6/30/2010 I PART I COMPUTATION OF RATIO OF COSTS TO CHARGES

618,225

19,619,006

WKST A COST CENTER DESCRIPTION WKST B, PT I THERAPY TOTAL RCE TOTAL DISALLOWANCE COSTS 5 LINE NO. COL. 27 ADJUSTMENT COSTS 3 1 INPAT ROUTINE SRVC CNTRS 3,628,923 2,304 236,112 ADULTS & PEDIATRICS 3,628,923 2,304 236,112 INTENSIVE CARE UNIT 33 36 NURSERY OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS 2,564,362 2,564,362 37 OPERATING ROOM 1,145,555 1,145,555 299,274 525,092 1,847,821 129,486 DELIVERY ROOM & LABOR ROO 299,274 525,092 39 ANESTHESIOLOGY 40 41 RADIOLOGY-DIAGNOSTIC 1,847,821 129,486 43 RADIOISOTOPE 1,991,596 401,768 75,993 466,368 100,304 LABORATORY 1,991,596 401,768 75,993 466,368 100,304 158,962 02 GEO PSYCH WHOLE BLOOD & PACKED RED RESPIRATORY THERAPY 44 46 49 50 53 PHYSICAL THERAPY ELECTROCARDIOLOGY 158,962 MEDICAL SUPPLIES CHARGED DRUGS CHARGED TO PATIENTS 55 56 609,216 609,216 1,072,665 1,072,665 OUTPAT SERVICE COST CNTRS 60 1,039,681 1,039,681 1,683,880 61 **EMERGENCY** 1,683,880 OBSERVATION BEDS (NON-DIS OTHER OUTPATIENT SERVICE 62 63 618.225 618,225 63 01 DIABETIC EDUCATION 72,241 72,241 50 RHC -BOWEN
51 RHC-WOMEN & FAMILY CLINIC
OTHER REIMBURS COST CNTRS
AMBULANCE SERVICES 327,880 327,880 63 1,239,523 1,239,523 65 20,237,231 618,225 101 20,237,231 SUBTOTAL

19,619,006

102

103

LESS OBSERVATION BEDS

TOTAL

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES I PROVIDER NO: I PREDD: I PREPARED 11/23/2010

I PROVIDER NO: I PREDD: I PREPARED 11/23/2010

I FROM 7/ 1/2009 I WORKSHEET C

I TO 6/30/2010 I PART I

WKST A	COST CENTER DESCRIPTION	INPATIENT	OUTPATIENT	TOTAL	COST OR	TEFRA INPAT-	PPS INPAT-
LINE NO		CHARGES	CHARGES	CHARGES	OTHER RATIO	IENT RATIO	IENT RATIO
22.12 110	•	6	7	8	9	10	11
	INPAT ROUTINE SRVC CNTRS	•	•	•	-		
25	ADULTS & PEDIATRICS	1,916,991		1,916,991			,
26	INTENSIVE CARE UNIT	4,528		4,528			
33	NURSERY	83,776		83,776			
36	OTHER LONG TERM CARE	2,427,041		2,427,041			
	ANCILLARY SRVC COST CNTRS	, ,					
37	OPERATING ROOM	311,721	1,240,876	1,552,597	.737832		
39	DELIVERY ROOM & LABOR ROO	94,065		94,065	3.181566	3.181566	
40	ANESTHESIOLOGY	190,133	942,532	1,132,665	.463590	.463590	
41	RADIOLOGY-DIAGNOSTIC	517,686	5,618,739	6,136,425	.301123		
43	RADIOISOTOPE	19,002	528,808	547,810	.236370		
44	LABORATORY	889,048	5,110,960	6,000,008	.331932		
	2 GEO PSYCH		445,919	445,919	.900989		
46	WHOLE BLOOD & PACKED RED	48,722	45,620	94,342	.805506		
49	RESPIRATORY THERAPY	273,016	408,860	681,876	.683948		
50	PHYSICAL THERAPY	128,860	21,337	150,197	.667816		
53	ELECTROCARDIOLOGY	48,047	415,361	463,408	.343028		
55	MEDICAL SUPPLIES CHARGED	694,857	736,421	1,431,278	.425645		
56	DRUGS CHARGED TO PATIENTS	825,173	947,130	1,772,303	.605238	.605238	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	1,000	364,584	365,584	2.843891		
61	EMERGENCY	19,643	1,562,587	1,582,230	1.064245		
62	OBSERVATION BEDS (NON-DIS	20,973	898,620	919,593	.672281	.672281	
63	OTHER OUTPATIENT SERVICE						
	1 DIABETIC EDUCATION		23,083	23,083	3.129619		
	0 RHC -BOWEN		368,708	368,708	.889267		
63 5	1 RHC-WOMEN & FAMILY CLINIC		1,027,118	1,027,118	1.206797	1.206797	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	SUBTOTAL	8,514,282	20,707,263	29,221,545			
102	LESS OBSERVATION BEDS						
103	TOTAL	8,514,282	20,707,263	29,221,545			

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION \*\*NOT A CMS WORKSHEET \*\* (07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C
SPECIAL TITLE XIX WORKSHEET T I TO 6/30/2010 I PART I

WKST A	COST CENTER DESCRIPTION	WKST B, PT I	THERAPY	TOTAL	RCE	TOTAL
LINE NO.	•	COL. 27	ADJUSTMENT	COSTS	DISALLOWANCE	COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,628,923		3,628,923		
26	INTENSIVE CARE UNIT	2,304		2,304		
33	NURSERY	236,112		236,112		
36	OTHER LONG TERM CARE	2,564,362		2,564,362		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,145,555		1,145,555		
39	DELIVERY ROOM & LABOR ROO	299,274		299,274		
40	ANESTHESIOLOGY	525,092		525,092		
41	RADIOLOGY-DIAGNOSTIC	1,847,821		1,847,821		
43	RADIOISOTOPE	129,486		129,486		
44	LABORATORY	1,991,596		1,991,596		
	2 GEO PSYCH	401,768		401,768		
46	WHOLE BLOOD & PACKED RED	75,993		75,993		
49	RESPIRATORY THERAPY	466,368		466,368		
50	PHYSICAL THERAPY	100,304		100,304		
53	ELECTROCARDIOLOGY	158,962		158,962		
55	MEDICAL SUPPLIES CHARGED	609,216		609,216		
56	DRUGS CHARGED TO PATIENTS	1,072,665		1,072,665		
30	OUTPAT SERVICE COST CNTRS	1,072,003		1,072,003		
		1 030 681		1,039,681		
60	CLINIC	1,039,681				
61	EMERGENCY	1,683,880		1,683,880		
62	OBSERVATION BEDS (NON-DIS	618,225		618,225		
63	OTHER OUTPATIENT SERVICE			72 244		
	1 DIABETIC EDUCATION	72,241		72,241	*	
	O RHC -BOWEN	327,880		327,880		
63 53	1 RHC-WOMEN & FAMILY CLINIC	1,239,523		1,239,523		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL	20,237,231		20,237,231		
102	LESS OBSERVATION BEDS	618,225		618,225		
103	TOTAL	19,619,006		19,619,006		
				•		

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION \*\*NOT A CMS WORKSHEET \*\* (07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C
SPECIAL TITLE XIX WORKSHEET T I TO 6/30/2010 I PART I

WKST	Α	COST CENTER DESCRIPTION	INPATIENT	OUTPATIENT	TOTAL	COST OR	TEFRA INPAT-	PPS INPAT-
LINE	NO.		CHARGES	CHARGES	CHARGES	OTHER RATIO	IENT RATIO	IENT RATIO
			6	7	8	9	10	11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,916,991		1,916,991			
26		INTENSIVE CARE UNIT	4,528		4,528			
33		NURSERY	83,776		83,776			
36		OTHER LONG TERM CARE	2,427,041		2,427,041			
		ANCILLARY SRVC COST CNTRS	_,,					
37		OPERATING ROOM	311,721	1,240,876	1,552,597	.737832	.737832	
39		DELIVERY ROOM & LABOR ROO	94,065	_,	94,065	3.181566		
40		ANESTHESIOLOGY	190,133	942.532	1,132,665	.463590		
41		RADIOLOGY-DIAGNOSTIC	517,686	5,618,739	6.136.425	.301123		
43		RADIOISOTOPE	19,002	528,808	547.810	.236370		
44		LABORATORY	889,048	5,110,960	6,000,008	.331932		
44	02	GEO PSYCH	005,010	445,919	445,919	.900989		
46	-	WHOLE BLOOD & PACKED RED	48.722	45,620	94,342	.805506		
49		RESPIRATORY THERAPY	273,016	408,860		.683948		
50		PHYSICAL THERAPY	128,860	21,337	150,197			
53		ELECTROCARDIOLOGY	48,047	415,361	463,408			
55		MEDICAL SUPPLIES CHARGED	694,857	736,421	1,431,278			
56		DRUGS CHARGED TO PATIENTS	825,173	947,130	1,772,303	.605238		
30		OUTPAT SERVICE COST CNTRS	023,173	347,130	1,112,505	.003230		
60		CLINIC	1,000	364,584	365.584	2,843891	2.843891	
61		EMERGENCY	19,643	1.562,587	1,582,230	1.064245		
62		OBSERVATION BEDS (NON-DIS	20,973	898,620	919.593	.672281		
63		OTHER OUTPATIENT SERVICE	20,973	030,020	313,333	.072201	.0,2201	
63	01	DIABETIC EDUCATION		23.083	23.083	3.129619	3.129619	
63		RHC -BOWEN		368,708	368,708	.889267		
63		RHC-WOMEN & FAMILY CLINIC		1,027,118	1,027,118	1.206797		
0.5	21	OTHER REIMBURS COST CNTRS		1,027,110	1,027,110	1,200/3/	1.200/3/	
65								
		AMBULANCE SERVICES	0 514 303	20 707 262	20 221 545			
101 102		SUBTOTAL	8,514,282	20,707,263	29,221,545			
		LESS OBSERVATION BEDS	0 514 303	20 707 262	20 221 545			
103		TOTAL	8,514,282	20,707,263	29,221,545			

WKST /		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III,COL. 27	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION	OPERATING COST REDUCTION AMOUNT S	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS	_	-	•			
37		OPERATING ROOM	1,145,555	323,629	821,926			1,145,555
39		DELIVERY ROOM & LABOR ROO	299,274	72,283	226,991			299,274
40		ANESTHESIOLOGY	525,092					525,092
41		RADIOLOGY-DIAGNOSTIC	1,847,821	390,120	1,457,701			1,847,821
43		RADIOISOTOPE	129,486		102,438			129,486
44		LABORATORY	1,991,596					1,991,596
44	02	GEO PSYCH	401,768					401,768
46		WHOLE BLOOD & PACKED RED	75,993		72,834			75,993
49		RESPIRATORY THERAPY	466,368		395,061			466,368
50		PHYSICAL THERAPY	100,304		78,685			100,304
53		ELECTROCARDIOLOGY	158,962		74,395			158,962
55		MEDICAL SUPPLIES CHARGED	609,216					609,216
56		DRUGS CHARGED TO PATIENTS	1,072,665	131,658	941,007			1,072,665
		OUTPAT SERVICE COST CNTRS						4 020 601
60		CLINIC	1,039,681					1,039,681
61		EMERGENCY	1,683,880					1,683,880
62		OBSERVATION BEDS (NON-DIS	618,225	,	618,225			618,225
63	^-	OTHER OUTPATIENT SERVICE	77 24		64 025			77 741
63		DIABETIC EDUCATION	72,241					72,241
63		RHC -BOWEN	327,880					327,880
63	эт	RHC-WOMEN & FAMILY CLINIC	1,239,523	3 54,074	1,185,449			1,239,523
65		OTHER REIMBURS COST CNTRS						
101		AMBULANCE SERVICES SUBTOTAL	12 005 520	1 707 504	12 007 046			13,805,530
101		LESS OBSERVATION BEDS	13,805,530 618,225		12,007,946 618,225			618,225
102		TOTAL						13,187,305
103		TOTAL	13,187,305	1,797,584	11,389,721			13,107,303

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

CHARGE RATIOS NET OF REDUCTIONS

I 14-1305

I FROM 7/ 1/2009

WORKSHEET C

I TO 6/30/2010

PART II

WKST LINE		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE	NO.		7	8	9
		ANCILLARY SRVC COST CNTRS	′	0	3
37		OPERATING ROOM	1,552,597	.737832	.737832
39		DELIVERY ROOM & LABOR ROO	94,065	3.181566	3.181566
40		ANESTHESIOLOGY	1,132,665	.463590	.463590
41		RADIOLOGY-DIAGNOSTIC	6,136,425	.301123	.301123
43		RADIOISOTOPE	547,810	.236370	.236370
44		LABORATORY	6,000,008	.331932	.331932
44	02	GEO PSYCH	445,919	.900989	.900989
46		WHOLE BLOOD & PACKED RED	94,342	.805506	.805506
49		RESPIRATORY THERAPY	681,876	.683948	.683948
50		PHYSICAL THERAPY	150,197	.667816	.667816
53		ELECTROCARDIOLOGY	463,408	. 343028	.343028
55		MEDICAL SUPPLIES CHARGED	1,431,278	.425645	.425645
56		DRUGS CHARGED TO PATIENTS	1,772,303	.605238	.605238
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	365,584	2.843891	2.843891
61		EMERGENCY	1,582,230	1.064245	
62		OBSERVATION BEDS (NON-DIS	919,593	.672281	.672281
63		OTHER OUTPATIENT SERVICE			
63		DIABETIC EDUCATION	23,083	3.129619	
63		RHC -BOWEN	368,708		
63	51	RHC-WOMEN & FAMILY CLINIC	1,027,118	1.206797	1,206797
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		SUBTOTAL	24,789,209		
102		LESS OBSERVATION BEDS	919,593		
103		TOTAL	23,869,616		

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION \*\*NOT A CMS WORKSHEET \*\* (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

CHARGE RATIOS NET OF REDUCTIONS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C

SPECIAL TITLE XIX WORKSHEET I TO 6/30/2010 I PART II

WKST LINE		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III,COL. 27	OPERATING COST NET OF CAPITAL COST	CAPITAL REDUCTION	OPERATING COST COST NET OF REDUCTION CAP AND OPER AMOUNT COST REDUCTION
			1	2	3	4	5 6
		ANCILLARY SRVC COST CNTRS					1 145 555
37		OPERATING ROOM	1,145,555		821,926		1,145,555
39		DELIVERY ROOM & LABOR ROO	299,274		226,991		299,274
40		ANESTHESIOLOGY	525,092				525,092 1 847 831
41		RADIOLOGY-DIAGNOSTIC	1,847,821				1,847,821
43		RADIOISOTOPE	129,486				129,486
44	^-	LABORATORY	1,991,596				1,991,596
44	UZ	GEO PSYCH	401,768		361,975		401,768
46		WHOLE BLOOD & PACKED RED	75,993				75,993
49		RESPIRATORY THERAPY	466,368				466,368
50		PHYSICAL THERAPY	100,304				100,304
53		ELECTROCARDIOLOGY	158,962				158,962
55		MEDICAL SUPPLIES CHARGED	609,216				609,216
56		DRUGS CHARGED TO PATIENTS	1,072,665	131,658	941,007		1,072,665
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	1,039,681	87,103	952,578		1,039,681
61		EMERGENCY	1,683,880	199,630	1,484,250		1,683,880
62		OBSERVATION BEDS (NON-DIS	618,225		618,225		618,225
63		OTHER OUTPATIENT SERVICE					
63	01	DIABETIC EDUCATION	72,241	7,415	64,826		72,241
63	50	RHC -BOWEN	327,880				327,880
63	51	RHC-WOMEN & FAMILY CLINIC					1,239,523
		OTHER REIMBURS COST CNTRS		•	, ,		
65		AMBULANCE SERVICES					
101		SUBTOTAL	13,805,530	1,797,584	12,007,946		13,805,530
102		LESS OBSERVATION BEDS	618,225		618,225		618,225
103		TOTAL	13,187,305		11,389,721		13,187,305

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION \*\*NOT A CMS WORKSHEET \*\* (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

CHARGE RATIOS NET OF REDUCTIONS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C

SPECIAL TITLE XIX WORKSHEET I TO 6/30/2010 I PART II

WKST	A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE	NO.				
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	1,552,597	.737832	.737832
39		DELIVERY ROOM & LABOR ROO	94,065	3.181566	3.181566
40		ANESTHESIOLOGY	1,132,665	.463590	.463590
41		RADIOLOGY-DIAGNOSTIC	6,136,425	.301123	.301123
43		RADIOISOTOPE	547,810	.236370	.236370
44		LABORATORY	6,000,008	.331932	.331932
44	02	GEO PSYCH	445,919	.900989	.900989
46		WHOLE BLOOD & PACKED RED	94,342	.805506	.805506
49		RESPIRATORY THERAPY	681,876	.683948	.683948
50		PHYSICAL THERAPY	150,197	.667816	.667816
53		ELECTROCARDIOLOGY	463,408	.343028	.343028
55		MEDICAL SUPPLIES CHARGED	1,431,278	.425645	.425645
56		DRUGS CHARGED TO PATIENTS	1.772.303	.605238	.605238
		OUTPAT SERVICE COST CNTRS	_,		
60		CLINIC	365,584	2.843891	2.843891
61		EMERGENCY	1,582,230		1.064245
62		OBSERVATION BEDS (NON-DIS	919,593	.672281	.672281
63		OTHER OUTPATIENT SERVICE	,		
63	01	DIABETIC EDUCATION	23,083	3,129619	3.129619
63		RHC -BOWEN	368,708		.889267
63		RHC-WOMEN & FAMILY CLINIC	1,027,118		1.206797
45	-	OTHER REIMBURS COST CNTRS	1,027,1110	2.200757	11200.3.
65		AMBULANCE SERVICES			
101		SUBTOTAL	24,789,209		
102		LESS OBSERVATION BEDS	919.593		
103		TOTAL	23,869,616		
-03		10106	23,003,010		

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(09/1997)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C

I TO 6/30/2010 I PART III

		·	TOTAL COST	TOTAL	TOTAL	CHARGE TO	TOTAL
WKST		COST CENTER DESCRIPTION	WKST B, PT I	ANCILLARY	INP ANCILLARY	CHARGE	INPATIENT
LINE	NO.		COL. 27	CHARGES	CHARGES	RATIO	COST
			1	2	3	4	5
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	1,145,555	1,552,597			
39		DELIVERY ROOM & LABOR ROO	299,274	94,065			
40		ANESTHESIOLOGY	525,092	1,132,665			
41		RADIOLOGY-DIAGNOSTIC	1,847,821	6,136,425			
43		RADIOISOTOPE	129,486	547,810			
44		LABORATORY	1,991,596	6,000,008			
44	02	GEO PSYCH	401,768	445,919			
46		WHOLE BLOOD & PACKED RED	75,993	94,342			
49		RESPIRATORY THERAPY	466,368	681,876			
50		PHYSICAL THERAPY	100,304	150,197			
50 53		ELECTROCARDIOLOGY	158,962	463,408			
55		MEDICAL SUPPLIES CHARGED	609,216	1,431,278			
56		DRUGS CHARGED TO PATIENTS	1,072,665	1,772,303			
		OUTPAT SERVICE COST CNTRS	_,	-,			
60		CLINIC	1,039,681	365,584			
61		EMERGENCY	1,683,880	1,582,230			
62		OBSERVATION BEDS (NON-DIS	618,225	919,593			
63		OTHER OUTPATIENT SERVICE	,	,			
63		DIABETIC EDUCATION	72,241	23,083			
63		RHC -BOWEN	327,880	368,708			
63		RHC-WOMEN & FAMILY CLINIC	1,239,523	1,027,118			
		OTHER REIMBURS COST CNTRS	2,233,323	1,027,110			
65		AMBULANCE SERVICES					
101		TOTAL	13,805,530	24,789,209			

FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(09/1996)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

SIT - I 14-1305 I FROM 7/ 1/2009 I WORKSHEET C

I TO 6/30/2010 I PART V Health Financial Systems MCRIF32

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

		TOTAL COST PR	OVIDER-BASED	TOTAL	TOTAL	TOTAL	RATIO OF OUT-	TOTAL OUT-
WKST A	A COST CENTER DESCRIPTION	WKST B, PT I	PHYSICIAN	COSTS	ANCILLARY	OUTPATIENT	PATIENT CHRGS	PATIENT
LINE I		COL. 27	ADJUSTMENT	••••	CHARGES	CHARGES	TO TTL CHARGES	COSTS
		1	2	3	4	5	6	7
	ANCILLARY SRVC COST CNTRS	_	_					
37	OPERATING ROOM	1,145,555		1,145,555	1,552,597			
39	DELIVERY ROOM & LABOR ROO	299,274		299.274	94,065			
40	ANESTHESIOLOGY	525,092		525.092	1,132,665			
41	RADIOLOGY-DIAGNOSTIC	1,847,821		1.847.821	6,136,425			
43	RADIOISOTOPE	129,486		129,486	547,810			
44	LABORATORY	1,991,596		1,991,596	6,000,008			
44	02 GEO PSYCH	401,768		401,768	445,919			
46	WHOLE BLOOD & PACKED RED	75,993		75,993	94,342			
49	RESPIRATORY THERAPY	466,368		466,368	681,876			
50	PHYSICAL THERAPY	100,304		100,304	150,197			
53	ELECTROCARDIOLOGY	158,962		158,962	463,408			
55	MEDICAL SUPPLIES CHARGED	609,216		609,216	1,431,278			
56	DRUGS CHARGED TO PATIENTS	1,072,665		1,072,665	1,772,303			
	OUTPAT SERVICE COST CNTRS	, ,						
60	CLINIC	1,039,681	1,037,686	2,077,367	365,584			
61	EMERGENCY	1,683,880	111,682	1,795,562	1,582,230			
62	OBSERVATION BEDS (NON-DIS	618,225		618,225	919,593			
63	OTHER OUTPATIENT SERVICE							
63	01 DIABETIC EDUCATION	72,241		72,241	23,083			
63	50 RHC -BOWEN							
63	\$1 RHC-WOMEN & FAMILY CLINIC							
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES							
101	TOTAL	12,238,127	1,149,368	13,387,495	23,393,383			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

Health Financial Systems MCRIF32 FOR	R MEMORIAL HOSPITA	AL ASSOCIATION I PROVIDE		ORM CMS-2552-96	(05/2004) PREPARED 11/23/2010
APPORTIONMENT OF MEDICAL, OTHER HEALTH SE	ERVICES & VACCINE		I FROM NT NO: I TO	7/ 1/2009 I 6/30/2010 I I	WORKSHEET D PART V
TITLE XVIII, PART B HO	OSPITAL				
		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
Cost Center Description	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS  37 OPERATING ROOM  39 DELIVERY ROOM & LABOR ROOM  40 ANESTHESIOLOGY  41 RADIOLOGY-DIAGNOSTIC  43 RADIOISOTOPE  44 LABORATORY  44 02 GEO PSYCH  46 WHOLE BLOOD & PACKED RED BLOOD CELLS  47 RESPIRATORY THERAPY  50 PHYSICAL THERAPY  51 ELECTROCARDIOLOGY  52 MEDICAL SUPPLIES CHARGED TO PATIENTS  53 DRUGS CHARGED TO PATIENTS  54 OUTPAT SERVICE COST CNTRS  55 DRUGS CHARGED TO PATIENTS  66 OLINIC  61 EMERGENCY  62 OBSERVATION BEDS (NON-DISTINCT PART)  63 OTHER OUTPATIENT SERVICE COST CENTER  64 OLINIC  65 SO RHC -BOWEN  66 ST RHC-WOMEN & FAMILY CLINIC  67 OTHER REIMBURS COST CNTRS  68 AMBULANCE SERVICES  101 SUBTOTAL  102 CRNA CHARGES  103 LESS PBP CLINIC LAB SYCS-	.737832 3.181566 .463590 .301123 .236370 .331932 .900989 .805506 .683948 .667816 .343028 .425645 .605238 2.843891 1.064245 .672281 3.129619		.737832 3.181566 .463590 .301123 .236370 .331932 .900989 .805506 .683948 .667816 .343028 .425645 .605238 2.843891 1.064245 .672281 3.129619		
PROGRAM ONLY CHARGES  104 NET CHARGES					

<sup>(</sup>A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

Heal	h Financial Systems MCRIF32 FC	R MEMORIAL HOSPITAL ASSO	OCIATION I PROVIDE		FORM CMS-2552-96	5(05/2004) CONTD PREPARED 11/23/2010
	APPORTIONMENT OF MEDICAL, OTHER HEALTH S	ERVICES & VACCINE COSTS		I FROM NT NO: I TO	7/ 1/2009 I 6/30/2010 I I	WORKSHEET D PART V
	TITLE XVIII, PART B	OSPITAL				
		Other All ( Outpatient Diagnostic	Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
	Cost Center Description	4	. 5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		508,697			
39 40	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY		356,655			
41	RADIOLOGY-DIAGNOSTIC		1,930,605			
43	RADIOISOTOPE		226,382			
44	LABORATORY		1,877,969			
44	02 GEO PSYCH		399,267			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS		42,759			
49	RESPIRATORY THERAPY		150,103			
50	PHYSICAL THERAPY		17,619			
53	ELECTROCARDIOLOGY		187,788			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		315,600			
56	DRUGS CHARGED TO PATIENTS		595,451			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		80,619			
61	EMERGENCY		434,204			
62 63	OBSERVATION BEDS (NON-DISTINCT PART)		417,087			
63	OTHER OUTPATIENT SERVICE COST CENTER 01 DIABETIC EDUCATION		6,978			
63	50 RHC -BOWEN		0,976			
63	51 RHC-WOMEN & FAMILY CLINIC					
0,5	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		7,547,783			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		7,547,783			

<sup>(</sup>A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

ION IN LIEU OF FORM CMS-2552-96(05/2004) CONTD
PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
14-1305 I FROM 7/ 1/2009 I WORKSHEET D
COMPONENT NO: I TO 6/30/2010 I PART V
14-1305 I I I Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

TITLE XVIII, PART B

HOSPITAL

		All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	Cost Center Description	9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	375,333		
39	DELIVERY ROOM & LABOR ROOM	,		
40	ANESTHESIOLOGY	165,342		
41	RADIOLOGY-DIAGNOSTIC	581,350		
43	RADIOISOTOPE	53,510		
44	LABORATORY	623,358		
44	02 GEO PSYCH	359,735		
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	34,443		
49	RESPIRATORY THERAPY	102,663		
50	PHYSICAL THERAPY	11,766		
53	ELECTROCARDIOLOGY	64,417		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	134,334		
56	DRUGS CHARGED TO PATIENTS	360,390		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	229,272		
61	EMERGENCY	462,099		
62	OBSERVATION BEDS (NON-DISTINCT PART)	280,400		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	01 DIABETIC EDUCATION	21,838		
63	50 RHC -BOWEN			
63	51 RHC-WOMEN & FAMILY CLINIC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	3,860,250		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES	3,860,250		

TITLE XVIII PART A

HOSPITAL

OTHER

PART I	- ALL PROVIDER COMPONENTS	1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,299
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,627
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,627
4 5	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	320
	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	240
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	319
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	17
	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	16
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	1,255
10	(EXCLUDING SWING-BED AND NEWBORN DAYS)	299
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	233
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	298
	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING	
	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
	YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	
15	(EXCLUDING SWING-BED DAYS) TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH	
	DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH	117.51
20	DECEMBER 31 OF THE COST REPORTING PERIOD	121.04
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	121.04
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,628,923
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	
	REPORTING PERIOD	1 000
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,998
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	1,937
26	REPORTING PERIOD TOTAL SWING-BED COST (SEE INSTRUCTIONS)	713,174
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,915,749
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,034,006
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2 024 006
30 31	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2,034,006 1.433501
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	774.27
34 35	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	<u> </u>
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,915,749
	COST DATE PERCENTARE	

IN LIEU OF FORM CMS-2552-96(05/2004) CONTD Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION PROVIDER NO: I PERIOD: I I FROM 7/ 1/2009 I I PREPARED 11/23/2010 COMPUTATION OF INPATIENT OPERATING COST 14-1305 WORKSHEET D-1 COMPONENT NO: 6/30/2010 I I TO 14-1305 TITLE XVIII PART A OTHER HOSPITAL PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,109.92 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,392,950 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM 1,392,950 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST PROGRAM PROGRAM TOTAL TOTAL AVERAGE I/P COST I/P DAYS PER DIEM DAYS COST 1 4 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT 42 HOSPITAL UNITS 7 2.304 43 INTENSIVE CARE UNIT 2,304 2 1.152.00 44 CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT 45 46 47 OTHER SPECIAL CARE 879,830 48 PROGRAM INPATIENT ANCILLARY SERVICE COST TOTAL PROGRAM INPATIENT COSTS 2,275,084 49 PASS THROUGH COST ADJUSTMENTS PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 50 51 52 53 TOTAL PROGRAM EXCLUDABLE COST TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS TARGET AMOUNT AND LIMIT COMPUTATION 54 55 56 PROGRAM DISCHARGES TARGET AMOUNT PER DISCHARGE TARGET AMOUNT DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT BONUS PAYMENT 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO. 58.04 RELIEF PAYMENT 58.04 RELIEF PAYMENT
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
59.03 PROGRAM DISCHARGES AFTER JULY 1
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
(SEE INSTRUCTIONS) (LTCH ONLY)
59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
(SEF INSTRUCTIONS) (LTCH ONLY) (SEE INSTRUCTIONS) (LTCH ONLY)

59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY) 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) PROGRAM INPATIENT ROUTINE SWING BED COST 6

PART II

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST	331,866
61	REPORTING PERIOD (SEE INSTRUCTIONS) MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST	330,756
62	REPORTING PERIOD (SEE INSTRUCTIONS) TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	662,622
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE	

TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

65

Health Financial Systems MCRIF32 COMPUTATION OF INPATIENT OPERATING COST		HOSPITAL ASSOCIA I I I I I	PROVIDER NO 14-1305 COMPONENT N 14-1305	: I PERIOD: I FROM 7	7/ 1/2009 I W	/2004) CONTD PARED 11/23/2010 PARED D-1 PART III
TITLE XVIII PART A	HOSPITAL		OTHER			
PART III - SKILLED NURSING FACILITY, NURS	INGFACILITY & I	CF/MR ONLY			4	
SKILLED NURSING FACILITY/OTHER NU SERVICE COST ADJUSTED GENERAL INPATIENT ROUTIN ROUTINE SERVICE COST MEDICALLY NECESSARY PRIVATE ROOM TOTAL PROGRAM GENERAL INPATIENT R CAPITAL-RELATED COST ALLOCATED TO PER DIEM CAPITAL-RELATED COSTS AGREGATE CHARGES TO BENEFICIARIE TOTAL PROGRAM ROUTINE SERVICE COST INPATIENT ROUTINE SERVICE COST INPATIENT ROUTINE SERVICE COST INPATIENT ROUTINE SERVICE COST INPATIENT ROUTINE SERVICE COST PE NPATIENT ROUTINE SERVICE COST PE REASONABLE INPATIENT ROUTINE SERVICE PROGRAM INPATIENT ANCILLARY SERVI UTILIZATION REVIEW - PHYSICIAN CO	COST APPLICABLE COUTINE SERVICE D INPATIENT ROUT:  SES FOR EXCESS CO. CITS FOR COMPARIS R DIEM LIMITATIO MITATION ICE COSTS CCES MPPENSATION	PER DIEM  TO PROGRAM COSTS INE SERVICE COST  STS ON TO THE COST			1	
PART IV - COMPUTATION OF OBSERVATION BED	COST					
83 TOTAL OBSERVATION BED DAYS 84 ADJUSTED GENERAL INPATIENT ROUTIN 85 OBSERVATION BED COST	IE COST PER DIEM	ı			557 1,109.92 618,225	
	COMPUTATION	OF OBSERVATION	BED PASS THROU	IGH COST		
86 OLD CAPITAL-RELATED COST 87 NEW CAPITAL-RELATED COST	COST 1	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST	
88 NON PHYSICIAN ANESTHETIST 89 MEDICAL EDUCATION 89.01 MEDICAL EDUCATION - ALLIED HEA 89.02 MEDICAL EDUCATION - ALL OTHER						

ION IN LIEU OF FORM CMS-2552-96(07/2009)
PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
14-1305 I FROM 7/ 1/2009 I WORKSHEET D-4
COMPONENT NO: I TO 6/30/2010 I
14-1305 I I Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST LINE		COST CENTER DESCRIPTION	RATIO COST TO CHARGES	CHARGES	INPATIENT COST 3
		THRAT BOUTTHE CRUC CHERC	1	2	3
25		INPAT ROUTINE SRVC CNTRS		060 733	
25		ADULTS & PEDIATRICS		969,732	
26		INTENSIVE CARE UNIT		4,528	
27		ANCILLARY SRVC COST CNTRS	777022	61 412	45 212
37		OPERATING ROOM	.737832	61,413	45,312
39		DELIVERY ROOM & LABOR ROOM	3.181566	22 905	15 672
40		ANESTHESIOLOGY	.463590	33,805	10,072
41		RADIOLOGY-DIAGNOSTIC		346,294	
43		RADIOISOTOPE	.236370		3,096
44		LABORATORY	.331932	461,789	153,283
44	02	GEO PSYCH	.900989	24 407	37 700
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.805506		27,788
49		RESPIRATORY THERAPY	.683948		
50		PHYSICAL THERAPY	.667816	30,214	
53		ELECTROCARDIOLOGY	. 343028	17,012	5,836
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.425645	315,803	134,420
56		DRUGS CHARGED TO PATIENTS	.605238	424,392	256,858
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	2.843891		
61		EMERGENCY	1.064245		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.672281	3,522	2,368
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	01	DIABETIC EDUCATION	3.129619		
63		RHC -BOWEN			
63	51	RHC-WOMEN & FAMILY CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		TOTAL		1,903,259	879,830
102		LESS PBP CLINIC LABORATORY SERVICES -		• •	·
		PROGRAM ONLY CHARGES			
103		NET CHARGES		1,903,259	
				, . , . ,	

FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(07/2009)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

RTIONMENT I 14-1305 I FROM 7/ 1/2009 I WORKSHEET D-4

I COMPONENT NO: I TO 6/30/2010 I

I 14-2305 I I Health Financial Systems MCRIF32

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

OTHER TITLE XVIII, PART A SWING BED SNF

WKST LINE		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS	-	_	•
25		ADULTS & PEDIATRICS			
26		INTENSIVE CARE UNIT			
20		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.737832		
39		DELIVERY ROOM & LABOR ROOM	3.181566		
40		ANESTHESIOLOGY	.463590		
41		RADIOLOGY-DIAGNOSTIC	.301123	9,824	2.958
43		RADIOISOTOPE	.236370	9,024	2,330
44		LABORATORY	.331932	52,088	17,290
44	Λ2	GEO PSYCH	.900989	32,000	17,230
46	UZ	WHOLE BLOOD & PACKED RED BLOOD CELLS	.805506	680	548
49		RESPIRATORY THERAPY	.683948	50.573	34,589
50		PHYSICAL THERAPY	.667816	84,433	56,386
53		ELECTROCARDIOLOGY	.343028	952	30,300
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.425645	63,412	26,991
56		DRUGS CHARGED TO PATIENTS	.605238	112,734	68,231
90			.603236	112,734	00,231
60		OUTPAT SERVICE COST CNTRS	2 042001		
60		CLINIC	2.843891		
61		EMERGENCY	1.064245		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.672281		
63	0.1	OTHER OUTPATIENT SERVICE COST CENTER	2 120610		
63		DIABETIC EDUCATION	3.129619		
63		RHC -BOWEN			
63	21	RHC-WOMEN & FAMILY CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES		374,696	207,320
101		TOTAL		3/4,090	207,320
102		LESS PBP CLINIC LABORATORY SERVICES -			
107		PROGRAM ONLY CHARGES		274 606	
103		NET CHARGES		374,696	

FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96 (07/2009)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

ENT SETTLEMENT I 14-1305 I FROM 7/ 1/2009 I WORKSHEET E

I COMPONENT NO: I TO 6/30/2010 I PART B

I 14-1305 I I Health Financial Systems MCRIF32

CALCULATION OF REIMBURSEMENT SETTLEMENT

# PART B - MEDICAL AND OTHER HEALTH SERVICES

ART B -	MEDICAL AND OTHER HEALTH SERVICES	
	HOSPITAL	
1.01 1.02 1.03 1.04 1.05 1.06	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS). PPS PAYMENTS RECEIVED INCLUDING OUTLIERS. ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO. LINE 1.01 TIMES LINE 1.03. LINE 1.02 DIVIDED BY LINE 1.04. TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS) ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101. INTERNS AND RESIDENTS ORGAN ACQUISITIONS	3,860,250
4 5	COST OF TEACHING PHYSICIANS TOTAL COST (SEE INSTRUCTIONS)	3,860,250
,	COMPUTATION OF LESSER OF COST OR CHARGES	3,000,230
	REASONABLE CHARGES	
6 7 8 9 10	ANCILLARY SERVICE CHARGES INTERNS AND RESIDENTS SERVICE CHARGES ORGAN ACQUISITION CHARGES CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS. TOTAL REASONABLE CHARGES	
11 12	CUSTOMARY CHARGES AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE	
13	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e). RATIO OF LINE 11 TO LINE 12	
14 15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS) EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16 17 17.01	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	3,898,853
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18 18.01	CAH DEDUCTIBLES CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	40,773 1,127,310
19 20 21	SUBTOTAL (SEE INSTRUCTIONS) SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.) DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	2,730,770
22 23	ESRD DIRECT MEDICAL EDUCATION COSTS SUBTOTAL	2,730,770
24 25	PRIMARY PAYER PAYMENTS SUBTOTAL	2,730,770
23		2,730,770
26	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) COMPOSITE RATE ESRD	
27 27.01	BAD DEBTS (SEE INSTRUCTIONS) ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES SUBTOTAL RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER	252,840 252,840 212,258 2,983,610
30	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION. OTHER ADJUSTMENTS (SPECIFY) OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING	
32	FROM DISPOSITION OF DEPRECIABLE ASSETS. SUBTOTAL	2,983,610
33 34	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS) INTERIM PAYMENTS	2,202,225
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	•
35 36	BALANCE DUE PROVIDER/PROGRAM PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	781,385 38,209
50 51 52 53 54	TO BE COMPLETED BY CONTRACTOR ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS) OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS) THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY TIME VALUE OF MONEY (SEE INSTRUCTIONS) TOTAL (SUM OF LINES 51 AND 53)	

ealth Financial Systems ANALYSIS OF PAYMENTS TO	MCRIF32 PROVIDERS FOR		 I I	PROVIDER 14-1305 COMPONENT	NO:	I	PERIOM FROM	OD: 7/	I	(11/1998) PREPARED 11/23/2010 WORKSHEET E-1
			т .	14-1305		T			I	

DESCRIPTION		INPATIENT- MM/DD/YYYY 1	-PART A AMOUNT 2	PAR MM/DD/YYYY	T B AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER 2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO. 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A		1	1,476, <sup>3</sup> 49 NONE	,	2,210,625 NONE
ZERO. (1)  ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER	.01 .02 .03	2/ 5/2010 5/14/2010	78,959 238,869	5/14/2010	130,119
ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROGRAM	.05 .50 .51 .52 .53			2/ 5/2010	138,519
SUBTOTAL 4 TOTAL INTERIM PAYMENTS	.99		317,828 1,794,177		-8,400 2,202,225
TO BE COMPLETED BY INTERMEDIARY  5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)  TENTATIVE TO PROVIDER TENTATIVE TO PROVIDER TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM	.01 .02 .03 .50 .51				
SUBTOTAL	.99		NONE		NONE

.02

319,031

NONE 781,385

2,983,610

HOSPITAL

AMOUNT (BALANCE DUE) SET BASED ON COST REPORT (1) 7 TOTAL MEDICARE PROGRAM LIABILITY 2,113,208 NAME OF INTERMEDIARY: INTERMEDIARY NO: SIGNATURE OF AUTHORIZED PERSON: \_\_\_

SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM

TITLE XVIII

6 DETERMINED NET SETTLEMENT

DATE: \_\_\_/\_\_\_

ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

Health Financial Systems ANALYSIS OF PAYMENTS TO	MCRIF32 PROVIDERS FOR	FOR MEMORIAL HO SERVICES RENDERED	SPITAL	I PRO I 14-	OVIDER NO: :	U OF FORM CMS-2552 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010	I PREPARED 11/23/201 I WORKSHEET E-1
						I	I
TITLE	XVIII	SWING BED	SNF				
	DESCRIPTION			INPATIE MM/DD/YYYY 1	ENT-PART A AMOUNT 2	PART MM/DD/YYYY 3	B AMOUNT 4
1 TOTAL INTERIM PAYMENT 2 INTERIM PAYMENTS PAYA EITHER SUBMITTED OR T INTERMEDIARY, FOR SER REPORTING PERIOD. IF ENTER A ZERO. 3 LIST SEPARATELY EACH AMOUNT BASED ON SUBSE RATE FOR THE COST REP OF EACH PAYMENT. IF ZERO. (1)	BLE ON INDIVID O BE SUBMITTED VICES RENDERED NONE, WRITE "N RETROACTIVE LU QUENT REVISION ORTING PERIOD.	UAL BILLS, TO THE IN THE COST ONE" OR  MP SUM ADJUSTMENT OF THE INTERIM ALSO SHOW DATE		•	591,658 NONE		NONE
ZERO. (I)	TZULDA TZULDA TZULDA TZULDA TZULDA TZULDA TZULDA	MENTS TO PROVIDER MENTS TO PROVIDER MENTS TO PROVIDER MENTS TO PROVIDER MENTS TO PROGRAM	.01 .02 .03 .04 .05 .50 .51	2/ 5/2010 5/14/2010	36,408 151,176		
SUBTOTAL 4 TOTAL INTERIM PAYMENT		MENTS TO PROGRAM	. 54 . 99		187,584 779,242		NONE
TO BE COMPLETED BY 5 LIST SEPARATELY EACH AFTER DESK REVIEW. A IF NONE, WRITE "NONE"	TENTATIVE SETT LSO SHOW DATE OR ENTER A ZE TENTAT TENTAT TENTAT TENTAT TENTAT TENTAT	OF EACH PAYMENT.	.01 .02 .03 .50 .51		NONE		NONE
6 DETERMINED NET SETTLE AMOUNT (BALANCE DUE) BASED ON COST REPORT	SETTLE (1)	MENT TO PROVIDER MENT TO PROGRAM	.99 .01 .02		90,954		NONE
7 TOTAL MEDICARE PROGRA	M LIABILITY				870,196		
NAME OF INTERMEDIARY: INTERMEDIARY NO:							
SIGNATURE OF AUTHORIZ	ED PERSON:	= =					

DATE: \_\_\_/\_\_\_

<sup>(1)</sup> ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION

CALCULATION OF REIMBURSEMENT SETTLEMENT SWING BEDS

ION IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)

PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

14-1305 I FROM 7/ 1/2009 I

COMPONENT NO: I TO 6/30/2010 I WORKSHEET E-2

14-2305 I I

TITLE XVIII

SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	669,248	
2 3	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR) ANCILLARY SERVICES (SEE INSTRUCTIONS)	209,393	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	597	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM		
7	(SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	878,641	
ğ	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	2,2,2,2	
10	SUBTOTAL	878,641	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS		
	APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	878,641	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER	8,445	
	RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		*
14	80% OF PART B COSTS		
15	SUBTOTAL	870,196	
16	OTHER ADJUSTMENTS (SPECIFY)	<b>,</b>	
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
	(SEE INSTRUCTIONS)	.=	
18	TOTAL	870,196	
19 20	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS) INTERIM PAYMENTS	779.242	
	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	779,242	
21	BALANCE DUE PROVIDER/PROGRAM	90.954	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	8,331	
	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	-,	

 Health Financial Systems
 MCRIF32
 FOR MEMORIAL HOSPITAL ASSOCIATION
 IN LIEU OF FORM CMS-2552-96-E-3 (04/2005)

 CALCULATION OF REIMBURSEMENT SETTLEMENT
 I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

 I 14-1305
 I FROM 7/ 1/2009
 I WORKSHEET E-3

 I COMPONENT NO: I TO 6/30/2010
 I PART II

 I 14-1305
 I TO 6/30/2010
 I PART II

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL	
1 1.01 2 3	INPATIENT SERVICES NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT ORGAN ACQUISITION COST OF TEACHING PHYSICIANS	2,275,084
4	SUBTOTAL	2,275,084
5 6	PRIMARY PAYER PAYMENTS TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,297,835
	COMPUTATION OF LESSER OF COST OR CHARGES	
7 8 9 10 11	REASONABLE CHARGES ROUTINE SERVICE CHARGES ANCILLARY SERVICE CHARGES ORGAN ACQUISITION CHARGES, NET OF REVENUE TEACHING PHYSICIANS TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE	
13	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14 15	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000) TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16 17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
18	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
19	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS COST OF COVERED SERVICES	2,297,835
20 21	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT) EXCESS REASONABLE COST	239,462
22 23	SUBTOTAL COINSURANCE	2,058,373
24	SUBTOTAL	2,058,373
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	54,835
	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	54,835 50,387
26	SUBTOTAL	2,113,208
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30 31	SUBTOTAL SEQUESTRATION ADJUSTMENT	2,113,208
32	INTERIM PAYMENTS	1,794,177
32.01 33	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY) BALANCE DUE PROVIDER/PROGRAM	319,031
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	22,017

Health Financial Systems

MCRIF32

BALANCE SHEET

FOR MEMORIAL HOSPITAL ASSOCIATION

IN LIEU OF FORM CMS-2552-96 (06/2003) PREPARED 11/23/2010

PROVIDER NO: I PERIOD: I 14-1305 I FROM 7/ 1/2009 I I TO 6/30/2010 I

WORKSHEET G

ENDOWMENT **GENERAL** SPECIFIC PI ANT **FUND** FUND PURPOSE FUND ASSETS FUND 4 1 CURRENT ASSETS CASH ON HAND AND IN BANKS TEMPORARY INVESTMENTS 1 2 3 253,148 98,106 NOTES RECEIVABLE 4,923,574 1,379,991 ACCOUNTS RECEIVABLE 5 6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE OTHER RECEIVABLES -2,230,000 253,896 156,175 INVENTORY PREPAID EXPENSES OTHER CURRENT ASSETS DUE FROM OTHER FUNDS TOTAL CURRENT ASSETS 10 11 4,834,890 FIXED ASSETS 12 LAND 12.01 13 LAND IMPROVEMENTS 13.01 LESS ACCUMULATED DEPRECIATION 521,757 341,880 -149,301 23,541,064 -3,113,532 14 BUILDINGS
14.01 LESS ACCUMULATED DEPRECIATION 15 LEASEHOLD IMPROVEMENTS 15.01 LESS ACCUMULATED DEPRECIATION 16 FIXED EQUIPMENT 16.01 LESS ACCUMULATED DEPRECIATION 17 AUTOMOBILES AND TRUCKS
17.01 LESS ACCUMULATED DEPRECIATION
18 MAJOR MOVABLE EQUIPMENT
18.01 LESS ACCUMULATED DEPRECIATION 6,614,307 -3,086,657 MINOR EQUIPMENT DEPRECIABLE 19.01 LESS ACCUMULATED DEPRECIATION
20 MINOR EQUIPMENT-NONDEPRECIABLE
21 TOTAL FIXED ASSETS 53,159 24,722,677 OTHER ASSETS 22 23 24 25 26 INVESTMENTS 7,821,759 DEPOSITS ON LEASES DUE FROM OWNERS/OFFICERS OTHER ASSETS 2,277,958 TOTAL OTHER ASSETS 10,099,717 TOTAL ASSETS 39,657,284

Health Financial Systems

MCRIF32

BALANCE SHEET

FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96 (06/2003)

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

I 14-1305 I FROM 7/ 1/2009 I
I TO 6/30/2010 I WORKSHEET G

PLANT FUND 4

ENDOWMENT
FUND
3

		GENERAL I	FUND 2	SPECIFIC PURPOSE 3	FUND 4
1	FUND BALANCE AT BEGINNING OF PERIOD	-	16,055,757	3	•
2 3	NET INCOME (LOSS) TOTAL		-986,596 15,069,161		
4 5	ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS	(SPECIFY) 137,224 159,901			
6 7 8	RESTRICTED CONTRIBUTIONS	109,258			
9 10	TOTAL ADDITIONS		406,383		
11 12	SUBTOTAL DEDUCTIONS (DEBIT ADJUSTMENTS)	(SPECIFY)	15,475,544		
13 14					
15 16 17					
18 19	TOTAL DEDUCTIONS FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		15,475,544		
		ENDOWMEN		PLANT FUND	0
1	FUND BALANCE AT BEGINNING OF PERIOD	ENDOWMEN' S	T FUND 6	PLANT FUND 7	8
1 2 3	OF PERIOD NET INCOME (LOSS) TOTAL	5			8
2 3 4 5	OF PERIOD NET INCOME (LOSS)	5			8
2 3 4 5 6 7	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS	5			8
2 3 4 5 6	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS	5			8
2 3 4 5 6 7 8	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS RESTRICTED CONTRIBUTIONS  TOTAL ADDITIONS SUBTOTAL	5 (SPECIFY)			8
2 3 4 5 6 7 8 9	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS RESTRICTED CONTRIBUTIONS  TOTAL ADDITIONS	5 (SPECIFY)			8
2 3 4 5 6 7 8 9 10 11 12 13 14 15	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS RESTRICTED CONTRIBUTIONS  TOTAL ADDITIONS SUBTOTAL	5 (SPECIFY)			8
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS RESTRICTED CONTRIBUTIONS  TOTAL ADDITIONS SUBTOTAL	5 (SPECIFY)			8
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	OF PERIOD NET INCOME (LOSS) TOTAL ADDITIONS (CREDIT ADJUSTMENTS) CAPITAL CONTRIBUTIONS UNREALIZED GAINS AND LOSS RESTRICTED CONTRIBUTIONS  TOTAL ADDITIONS SUBTOTAL	5 (SPECIFY)			8

Health Financial Systems	MCRIF32	FOR MEMORIAL HOSPITAL ASS	OCIAT	ON	IN LIEU	OF F	ORM CMS-2552-		
•			I	<b>PROVIDER</b>	NO:	I PER	IOD:	I	PREPARED 11/23/2010
STATEMENT OF PATIS	ENT REVENUES A	ND OPERATING EXPENSES	I	14-1305		I FRO	M 7/ 1/2009	Ι	WORKSHEET G-2
			-			T TO	6/20/2010	т	DADTS T & TT

## PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
	GENERAL INPATIENT ROUTINE CARE SERVICES	-	_	
1	00 HOSPITAL	2,034,006		2,034,006
4	00 SWING BED - SNF			
5	00 SWING BED - NF	2 427 041		2 427 041
8 9	00 OTHER LONG TERM CARE 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,427,041		2,427,041 4,461,047
9	INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS	4,461,047		4,401,047
10	00 INTENSIVE CARE UNIT	4,528		4,528
15	00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	4,528		4,528
16	00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,465,575		4,465,575
17	00 ANCILLARY SERVICES	4,148,843		4,148,843
18	00 OUTPATIENT SERVICES	•••••	24,115,717	24,115,717
18	50 RHC -BOWEN		368,708	368,708
18	51 RHC-WOMEN & FAMILY CLINIC		1,027,118	1,027,118
20	00 AMBULANCE SERVICES			
24	00 PHYSICIAN OFFICE		280,523	280,523
25	00 TOTAL PATIENT REVENUES	8,614,418	25,792,066	34,406,484
	PART II	-OPERATING EXPENSES		
26	00 OPERATING EXPENSES		22,400,757	
	DD (SPECIFY)		22,400,131	
	00 BAD DEBTS	888,542		
28	00			
29	00			
30	00			
31	00			
32	00			
33_	00 TOTAL ADDITIONS		888,542	
	EDUCT (SPECIFY)			
34 35	00 DEDUCT (SPECIFY) 00			
36	00			
37	00		•	
38	00			
39	00 TOTAL DEDUCTIONS			
40	00 TOTAL OPERATING EXPENSES		23,289,299	

### DESCRIPTION

4	TOTAL DATTENT DEVENUES	34 406 484
1 2	TOTAL PATIENT REVENUES	34,406,484
2	LESS: ALLOWANCES AND DISCOUNTS ON NET PATIENT REVENUES	13,381,179 21.025.305
3 4	LESS: TOTAL OPERATING EXPENSES	21,023,303
5	NET INCOME FROM SERVICE TO PATIENT	
,	OTHER INCOME	-2,263,994
-		20 722
6 7	CONTRIBUTIONS, DONATIONS, BEQUES	30,722
8	INCOME FROM INVESTMENTS	252,784
	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	62 257
10	PURCHASE DISCOUNTS	63,357
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	100 570
14	REVENUE FROM MEALS SOLD TO EMPLO	198,576
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	4,656
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	4-2-24
22	RENTAL OF HOSPITAL SPACE	153,941
23	GOVERNMENTAL APPROPRIATIONS	450,599
24	HOSPITAL OTHER INCOME	45,444
	EQUITY EARNINGS ON INVESTMENTS	13,763
	NURSING HOME OTHER INCOME	41,039
	NAUVOO APARTMENTS	34,200
24.04		
24.05		
25	TOTAL OTHER INCOME	1,289,081
26		-974,913
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28	LOSS ON DISPOSAL OF FIXED ASSETS	11,683
29		
30	TOTAL OTHER EXPENSES	11,683
31	NET INCOME (OR LOSS) FOR THE PERIO	-986,596

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

		COMPENSATION 1	OTHER COSTS	TOTAL 3	RECLASSIFI- CATION 4
1 2 3 4 5 6 7 8 9	FACILITY HEALTH CARE STAFF COSTS PHYSICIAN PHYSICIAN ASSISTANT NURSE PRACTITIONER VISITING NURSE OTHER NURSE CLINICAL PSYCHOLOGIST CLINICAL SOCIAL WORKER LABORATORY TECHNICIAN OTHER FACILITY HEALTH CARE STAFF COSTS SUBTOTAL (SUM OF LINES 1-9)	92,012 70,428 162,440		92,012 70,428 162,440	-18,338 -18,338
11 12 13 14	COSTS UNDER AGREEMENT PHYSICIAN SERVICES UNDER AGREEMENT PHYSICIAN SUPERVISION UNDER AGREEMENT OTHER COSTS UNDER AGREEMENT SUBTOTAL (SUM OF LINES 11-13)		30,000 30,000	30,000 30,000	
15 16 17 18 19	OTHER HEALTH CARE COSTS MEDICAL SUPPLIES TRANSPORTATION (HEALTH CARE STAFF) DEPRECIATION-MEDICAL EQUIPMENT PROFESSIONAL LIABILITY INSURANCE OTHER HEALTH CARE COSTS		8,000 28,069	8,000 28,069	2,570
20 21 22	ALLOWABLE GME COSTS SUBTOTAL (SUM OF LINES 15-20) TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	162,440	36,069 66,069	36,069 228,509	2,570 -15,768
23 24 25 26 27 28	COSTS OTHER THAN RHC/FQHC SERVICES PHARMACY DENTAL OPTOMETRY ALL OTHER NONREIMBURSABLE COSTS NONALLOWABLE GME COSTS TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 30 31 32	FACILITY OVERHEAD FACILITY COSTS ADMINISTRATIVE COSTS TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30) TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	162,440	6,404 6,404 72,473	6,404 6,404 234,913	-15,768

Health Financial Systems	MCRIF32	FOR MEMORIAL	HOSPITAL	ASSOCIATION	ON	IN L	IEU OF FOR		M-1 (11/1998)
ANALYSIS OF PROVIDER-BASED FEDERALLY QUALIFIED HEALTH				I I I	PROVIDER 14-1305 COMPONENT 14-3456			I	PREPARED 11/23/2010 WORKSHEET M-1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 2 3 4 5	FACILITY HEALTH CARE STAFF COSTS PHYSICIAN PHYSICIAN ASSISTANT NURSE PRACTITIONER VISITING NURSE OTHER NURSE	92,012		92,012
5 6 7 8 9 10	CLINICAL PSYCHOLOGIST CLINICAL SOCIAL WORKER LABORATORY TECHNICIAN OTHER FACTLITY HEALTH CARE STAFF COSTS SUBTOTAL (SUM OF LINES 1-9)	52,090 144,102		52,090 144,102
11 12 13 14	COSTS UNDER AGREEMENT PHYSICIAN SERVICES UNDER AGREEMENT PHYSICIAN SUPERVISION UNDER AGREEMENT OTHER COSTS UNDER AGREEMENT SUBTOTAL (SUM OF LINES 11-13)	30,000 30,000		30,000 30,000
15 16 17	OTHER HEALTH CARE COSTS MEDICAL SUPPLIES TRANSPORTATION (HEALTH CARE STAFF) DEPRECIATION-MEDICAL EQUIPMENT	8,000 2,570		8,000 2,570
18 19 20 21 22	PROFESSIONAL LIABILITY INSURANCE OTHER HEALTH CARE COSTS ALLOWABLE GME COSTS SUBTOTAL (SUM OF LINES 15-20) TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	28,069 38,639 212,741		28,069 38,639 212,741
23 24 25 26 27 28	COSTS OTHER THAN RHC/FQHC SERVICES PHARMACY DENTAL OPTOMETRY ALL OTHER NONREIMBURSABLE COSTS NONALLOWABLE GME COSTS TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
29 30 31 32	FACILITY OVERHEAD FACILITY COSTS ADMINISTRATIVE COSTS TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30) TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	6,404 6,404 219,145	-3,076 -3,076 -3,076	3,328 3,328 216,069

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

		COMPENSATION 1	OTHER COSTS	TOTAL 3	RECLASSIFI- CATION 4
1 2 3 4 5 6	FACILITY HEALTH CARE STAFF COSTS PHYSICIAN PHYSICIAN ASSISTANT NURSE PRACTITIONER VISITING NURSE OTHER NURSE CLINICAL PSYCHOLOGIST CLINICAL SOCIAL WORKER	260,538 179,133		260,538 179,133	7,490 -17,913
8 9 10	LABORATORY TECHNICIAN OTHER FACILITY HEALTH CARE STAFF COSTS SUBTOTAL (SUM OF LINES 1-9)	96,476 536,147	5,206 5,206	101,682 541,353	-23,645 -34,068
11 12 13 14	COSTS UNDER AGREEMENT PHYSICIAN SERVICES UNDER AGREEMENT PHYSICIAN SUPERVISION UNDER AGREEMENT OTHER COSTS UNDER AGREEMENT SUBTOTAL (SUM OF LINES 11-13)		126,638 126,638	126,638 126,638	
15 16 17 18	OTHER HEALTH CARE COSTS MEDICAL SUPPLIES TRANSPORTATION (HEALTH CARE STAFF) DEPRECIATION-MEDICAL EQUIPMENT PROFESSIONAL LIABILITY INSURANCE		46,722	46,722	
19 20 21	OTHER HEAD CARE COSTS ALLOWABLE GME COSTS SUBTOTAL (SUM OF LINES 15-20)		37,234 83,956	37,234 83,956	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	536,147	215,800	751,947	-34,068
23 24 25 26 27 28	COSTS OTHER THAN RHC/FQHC SERVICES PHARMACY DENTAL OPTOMETRY ALL OTHER NONREIMBURSABLE COSTS NONALLOWABLE GME COSTS TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 30 31 32	FACILITY OVERHEAD FACILITY COSTS ADMINISTRATIVE COSTS TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30) TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	536,147	111,931 111,931 327,731	111,931 111,931 863,878	4,632 4,632 -29,436

		RECLASSIFIED		NET EXPENSES
		TRIAL		FOR
		BALANCE	ADJUSTMENTS	ALLOCATION
		5	6	7
		.5	U	,
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	268,028		268,028
2	PHYSICIAN ASSISTANT	161,220		161,220
3	NURSE PRACTITIONER	101,110		
4	VISITING NURSE			
Ś	OTHER NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
ğ	OTHER FACILITY HEALTH CARE STAFF COSTS	78.037		78,037
10	SUBTOTAL (SUM OF LINES 1-9)	507,285		507,285
	200.0002 (000.00 22023 2 3)	307,203		,
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	126,638		126,638
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	126,638		126,638
	•	•		
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	46,722		46,722
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	37,234		37,234
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	83,956		83,956
22	TOTAL COST OF HEALTH CARE SERVICES	717,879		717,879
	(SUM OF LINES 10, 14, AND 21)			
	COCTS OTHER THAN BUG / Tolle ADDITION			
22	COSTS OTHER THAN RHC/FQHC SERVICES			
23 24	PHARMACY			
25	DENTAL			
26	OPTOMETRY			
27	ALL OTHER NONREIMBURSABLE COSTS			
28	NONALLOWABLE GME COSTS			
20	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	116,563	-10,374	106.189
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	116,563	-10,374	106,189
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	834,442	-10,374	824,068
			,	F

	VISITS AND PRODUCTIVITY				
		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS			4,200	
2	PHYSICIAN ASSISTANTS	.92	3,215	2,100	1,932
3	NURSE PRACTITIONERS			2,100	1 022
4	SUBTOTAL (SUM OF LINES 1-3)	.92	3,215		1,932
5 6	VISITING NURSE CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7) PHYSICIAN SERVICES UNDER AGREEMENTS	.92	3,215		
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RH	C/FOHC SERVICES			
10	TOTAL COSTS OF HEALTH CARE SERVICES	212,741			
· -	(FROM WORKSHEET M-1, COLUMN 7, LINE 22)				
11	TOTAL NONREIMBURSABLE COSTS				
12	(FROM WORKSHEET M-1, COLUMN 7, LINE 28) COST OF ALL SERVICES (EXCLUDING OVERHEAD)	212.741			
12	(SUM OF LINES 10 AND 11)	212,741			
13	RATIO OF RHC/FQHC SERVICES	1.000000			
	(LINE 10 DIVIDED BY LINE 12)				
14	TOTAL FACILITY OVERHEAD	3,328			
15	(FROM WORKSHEET M-1, COLUMN 7, LINE 31) PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	111,811			
	(SEE INSTRUCTIONS)	222,022		•	
16	TOTAL OVERHEAD	115,139			
	(SUM OF LINES 14 AND 15)				
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	115,139			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	115,139			
	(LINE 13 X LINE 18)				
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	327,880			
	(SUM OF LINES 10 AND 19)	GREATER OF			
		COL. 2 OR			
		COL. 4			
		5			
	POSITIONS				
1	PHYSICIANS				
2	PHYSICIAN ASSISTANTS				
3	NURSE PRACTITIONERS	2.245			
4	SUBTOTAL (SUM OF LINES 1-3)	3,215			
5 6	VISITING NURSE CLINICAL PSYCHOLOGIST				
7	CLINICAL PSYCHOLOGIST CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	3,215			
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

<sup>(1)</sup> THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

	RHC 2				
	VISITS AND PRODUCTIVITY				
		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	.90	2,217	4,200	3,780
2	PHYSICIAN ASSISTANTS	.93	2,056	2,100	1,953
3	NURSE PRACTITIONERS	.90	1,683	2,100	1,890
4	SUBTOTAL (SUM OF LINES 1-3)	2.73	5,956		7,623
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8 9	TOTAL FTES AND VISITS (SUM OF LINES 4-7) PHYSICIAN SERVICES UNDER AGREEMENTS	2.73	5,956		
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQ	IC SERVICES			
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	717,879			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	717,879			
	(SUM OF LINES 10 AND 11)				
13	RATIO OF RHC/FOHC SERVICES	1.000000			
4.	(LINE 10 DIVIDED BY LINE 12)	100 100			
14	TOTAL FACILITY OVERHEAD	106,189			
15	(FROM WORKSHEET M-1, COLUMN 7, LINE 31)	415 455			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	415,455			
16	(SEE INSTRUCTIONS) TOTAL OVERHEAD	521,644			
10	(SUM OF LINES 14 AND 15)	321,044			
17	ALLOWABLE GME OVERHEAD				
4.	(SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	521,644			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	521,644			
	(LINE 13 X LINE 18)	,			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1,239,523			
	(SUM OF LINES 10 AND 19)				
		GREATER OF COL. 2 OR COL. 4 5			
	POSITIONS				
1	PHYSICIANS				
2 3	PHYSICIAN ASSISTANTS				
4	NURSE PRACTITIONERS	7,623			
5	SUBTOTAL (SUM OF LINES 1-3) VISITING NURSE	. 7,023			
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL PSYCHOLOGISY CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	7,623			
9	PHYSICIAN SERVICES UNDER AGREEMENTS	.,525			
-					

<sup>(1)</sup> THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULA	nancial Systems MCRIF32 ATION OF REIMBURSEMENT SETTLEMENT C/FQHC SERVICES		I PROVIDI I 14-130 I COMPONI	IN LIEU OF FO ER NO: I PERIO 5 I FROM ENT NO: I TO 6 I	D: I 7/ 1/2009 I 6/30/2010 I I	PREPARED 11/23/2010
	TITLE XVIII	RHC 1			4	
1 2 3 4 5	DETERMINATION OF RATE FOR RHC/FQHC TOTAL ALLOWABLE COST OF RHC/FQHC (FROM WORKSHEET M-2, LINE 20) COST OF VACCINES AND THEIR ADMIN: (FROM WORKSHEET M-4, LINE 15) TOTAL ALLOWABLE COST EXCLUDING V/ (LINE 1 MINUS LINE 2) TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, L: PHYSICIANS VISITS UNDER AGREEMEN' (FROM WORKSHEET M-2, COLUMN 5, L: TOTAL ADJUSTED VISITS (LINE 4 PLI ADJUSTED COST PER VISIT (LINE 3 I	HC SERVICES SERVICES ISTRATION ACCINE INE 8) Inc 10	327,880 6,177 321,703 3,215 3,215 100.06 CALCULAT. PRIOR TO JANUARY 1			
			1	2		
	PER VISIT PAYMENT LIMIT (FROM CM: 505 OR YOUR INTERMEDIARY)	5 PUB. 27, SEC.	76.84	77.76		
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)		100.06	100.06		
	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING	MENTAL MEALTH		595	*	
	SERVICES (FROM INTERMEDIARY RECO	RDS)				
	PROGRAM COST EXCLUDING COSTS FOR SERVICES (LINE 9 X LINE 10)	MENTAL HEALTH		59,536		
12	PROGRAM COVERED VISITS FOR MENTAL (FROM INTERMEDIARY RECORDS)	L HEALTH SERVICES				
13	PROGRAM COVERED COSTS FROM MENTA	L HEALTH SERVICES				
14	(LINE 9 X LINE 12) LIMIT ADJUSTMENT FOR MENTAL HEAL	TH SERVICES				
15	(LINE 13 X 62.5%) GRADUATE MEDICAL EDUCATION PASS	THROUGH COST				
16	(SEE INSTRUCTIONS) TOTAL PROGRAM COST (SUM OF LINES	11. 14. AND 15.		59,536		
	COLUMNS 1, 2 AND 3)* PRIMARY PAYER AMOUNT	,,,		,		
17	LESS: BENEFICIARY DEDUCTIBLE			7,512		
18	(FROM INTERMEDIARY RECORDS) NET PROGRAM COST EXCLUDING VACCI			52,024		
19	(LINE 16 MINUS SUM OF LINES 16.0) REIMBURSABLE COST OF RHC/FQHC SE			41,619		
	VACCINE (80% OF LINE 18) PROGRAM COST OF VACCINES AND THE	·		2,210		
	(FROM WORKSHEET M-4, LINE 16)	TI UNDITITE LIVELEDIN				
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)			43,829		
	REIMBURSABLE BAD DEBTS (SEE INST REIMBURSABLE BAD DEBTS FOR DUAL BENEFICIARIES (SEE INSTRUCTIONS)					
	OTHER ADJUSTMENTS (SPECIFY) NET REIMBURSABLE AMOUNT (LINES 2	1 PHIS 22 PHIS OF		43,829		
	MINUS LINE 23) INTERIM PAYMENTS			,		
25.01	TENTATIVE SETTLEMENT (FOR FISCAL ONLY)	INTERMEDIARY USE		43,246		
	BALANCE DUE COMPONENT/PROGRAM	13		583		
	(LINE 24 MINUS LINES 25 AND 25.0) PROTESTED AMOUNTS (NONALLOWABLE OF ACCORDANCE WITH CMS PUB. 15-1) SECTION 115.2	COST REPORT ITEMS)				

<sup>(1)</sup> LINES & THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

<sup>\*</sup> FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

### TITLE XVIII

*	FOR 1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	UCATION PASS THROUGH COS 1,239,523	т.
	2	(FROM WORKSHEET M-2, LINE 20) COST OF VACCINES AND THEIR ADMINISTRATION	1,466	
	3	(FROM WORKSHEET M-4, LINE 15) TOTAL ALLOWABLE COST EXCLUDING VACCINE	1,238,057	
	4	(LINE 1 MINUS LINE 2)		
		TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	7,623	
	5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
	6 7	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5) ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	7,623 162.41	
			CALCULATIO	N OF LIMIT (1)
			PRIOR TO JANUARY 1 1	
	8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC.	76.84	77.76
	9	505 OR YOUR INTERMEDIARY) RATE FOR PROGRAM COVERED VISITS	162.41	162.41
	,	(SEE INSTRUCTIONS)	102,41	102.11
	10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH		351
		SERVICES (FROM INTERMEDIARY RECORDS)		
	11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		57,006
-	12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
:	13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
:	14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 x 62.5%)		
:	15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST		
	16	(SEE INSTRUCTIONS) TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15,		57,006
:	16.01	COLUMNS 1, 2 AND 3)* PRIMARY PAYER AMOUNT		
	17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		4,867
:	18	NET PROGRAM COST EXCLUDING VACCINES		52,139
:	19	(LINE 16 MINUS SUM OF LINES 16.01 AND 17) REIMBURSABLE COST OF RHC/FOHC SERVICES, EXCLUDING		41,711
;	20	VACCINE (80% OF LINE 18) PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION		276
	21	(FROM WORKSHEET M-4, LINE 16) TOTAL REIMBURSABLE PROGRAM COST		41,987
	22	(LINE 19 PLUS LINE 20) REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		·
		REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE		
	23	BENEFICIARIES (SEE INSTRUCTIONS) OTHER ADJUSTMENTS (SPECIFY)		
-	24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		41,987
	25 25 01	INTERIM PAYMENTS TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE		56,072
		ONLY)		14 005
	26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	·	-14,085
	27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

<sup>(1)</sup> LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

<sup>\*</sup> FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96 M-4 (09/2000)

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

TION IN LIEU OF FORM CMS-2552-96 M-4 (09/2000)

PROVIDER NO: I PERIOD: I PREPARED 11/23/2010

14-1305 I FROM 7/ 1/2009 I WORKSHEET M-4

COMPONENT NO: I TO 6/30/2010 I

14-3456 I I

TITLE XVIII

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	144,102	144,102	144,102	144,102
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.001124	.006979	.003045	
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	162	1,006	439	
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	984	1,417		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,146	2,423	439	
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	212,741	212,741	212,741	212,741
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	115.139	115,139	115,139	115,139
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.005387	.011389	.002064	
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	620	1,311	238	
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	1,766	3,734	677	
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	24	149	65	
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	73.58	25.06	10.42	
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	16	40	3	
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	1,177	1,002	31	
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		6,177		
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		2,210		

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

ON IN LIEU OF FORM CMS-2552-96 M-4 (09/2000)
PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
14-1305 I FROM 7/ 1/2009 I WORKSHEET M-4
COMPONENT NO: I TO 6/30/2010 I
14-3405 I I

TITLE XVIII

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	507,285	507,285	507,285	507,285
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000039	.000567		
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	20	288		
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	123	418		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	143	706		
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	717,879	717,879	717,879	717,879
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	521,644	521,644	521,644	521,644
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000199	.000983		•
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	104	513		
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	247	1,219		
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	3	44		
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	82.33	27.70		
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	4		
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	165	111		
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		1,466		
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		276		

														= (44 (4000)
a I	lth Fina	incial	Syster	ns	MCRIF32	FOR MEMORIAL	HOSPITAL	. ASSOCIAT I	'ION PROVIDER		OF FO		-96 I	M-5 (11/1998) PREPARED 11/23/2010
					PITAL-BASE	D RHC/FQHC PROVI	DER FOR	I	14-1305 COMPONEN	I			I	WORKSHEET M-5
٠.	.NVICES	KLHOCK		RHC	[ ] FQHC	ANIES		ī	14-345	Ī		0, 50, 2020	Ī	
						RHC 1								
					DESCRIPTION	N						PART	В	
											MM/DD	/ / / / / / / / / / / / / / / / / / / /	,	AMOUNT 2
1	L TOTAL	INTER	M PAY	MENTS P	AID TO PRO	VIDER						•		39,535
2					ON INDIVII E SUBMITTE	DUAL BILLS,							NOI	NE
	INTERN	<b>IEDIAR</b> Y	, FOR	SERVIC	ES RENDEREI	D IN THE COST								
		ING PE		IF NON	IE, WRITE "I	NONE" OR								
3	3 LIST S	EPARAT	TELY E			UMP_SUM_ADJUSTME								
						N OF THE INTERIM  . ALSO SHOW DAT								
	OF EAC	H PAYN				NONE" OR ENTER A								
	ZERO.	(1)			ADJUS"	TMENTS TO PROVID	ER .01				2/	5/2010		3,711
					ADJUS'	TMENTS TO PROVID	ER .02							
						TMENTS TO PROVID TMENTS TO PROVID								
					ADJUS"	TMENTS TO PROVID	ER .05							
						TMENTS TO PROGRA TMENTS TO PROGRA								
						TMENTS TO PROGRA	M .52							
						TMENTS TO PROGRA TMENTS TO PROGRA								
	SUBTO	AL			ADJUJ	IMENIS TO PROGRA	.99							3,711
4	1 TOTAL	INTER	IM PAY	MENTS									•	43,246
					ERMEDIARY									
						TLEMENT PAYMENT OF EACH PAYMENT								
					ENTER A Z	ERO. (1)								
						TIVE TO PROVIDER TIVE TO PROVIDER								
						TIVE TO PROVIDER								
						TIVE TO PROGRAM	.50 .51							
						TIVE TO PROGRAM	.52							
	SUBTO		HET CE	TT:		EMENT TO DROVED	.99 R .01						NO	NE 583
١		(BALA				EMENT TO PROVIDE EMENT TO PROGRAM								303
				ORT (1)	.IABILITY									43,829
•	IUIAL	MEDIC	ANE PRI	CORAM L	TWOILTIT									13,023
	NAME (	OF INTE	ERMEDT.	ARY:										
		EDIAR												
	SIGNA	TURE O	F AUTH	ORIZED	PERSON: _					 				
	DATE:	/_	/_	_										

Health Financial Systems

<sup>(1)</sup> ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

Health Financial Systems MCRIF32  ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RI SERVICES RENDERED TO PROGRAM BENEFICIARIN  [X] RHC [] FQHC		1	PROVIDER NO: I 14-1305 I	TO 6/30/2010	I PREPARED 11/23/2010 I WORKSHEET M-5
	RHC 2				
DESCRIPTION				PART MM/DD/YYYY	B AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDI 2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL EITHER SUBMITTED OR TO BE SUBMITTED TO INTERMEDIARY, FOR SERVICES RENDERED IN REPORTING PERIOD. IF NONE, WRITE "NONI ENTER A ZERO.	L BILLS, D THE N THE COST			1	2 45,534 NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP AMOUNT BASED ON SUBSEQUENT REVISION OF RATE FOR THE COST REPORTING PERIOD. A OF EACH PAYMENT. IF NONE, WRITE "NONI ZERO. (1)	F THE INTERIM ALSO SHOW DATE				
ADJUSTMEI	NTS TO PROVIDER .C NTS TO PROVIDER .C NTS TO PROVIDER .C NTS TO PROVIDER .C NTS TO PROGRAM .S NTS TO PROGRAM .S	01 02 03 04 05 50 51 52 53		2/ 5/2010	10,538
ADJUSTME SUBTOTAL 4 TOTAL INTERIM PAYMENTS		54 99			10,538 56,072
TENTATIV TENTATIV TENTATIV TENTATIV	EACH PAYMENT (1) E TO PROVIDER E TO PROVIDER E TO PROVIDER TO PROGRAM E TO PROGRAM	01 02 03 50 51 52			
SUBTOTAL 6 DETERMINED NET SETTLEMENT SETTLEME	ont to provider	99 01 02			NONE 14,085 41,987
NAME OF INTERMEDIARY: INTERMEDIARY NO:					
SIGNATURE OF AUTHORIZED PERSON:					
DATE:/					

ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE. (1)